

EEOICPA Program Process Enhancements and Efficiency Improvements

Presented To:



**United States Department of Energy
Office of Worker Advocacy**

November 14, 2003

IDS Center, Suite 700 • 80 South 8th Street • Minneapolis, Minnesota 55402
(612) 333-3323 • Fax (612) 373-7270



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Executive Summary

Hays Companies is pleased to have had the opportunity to work in conjunction with Westwood Group to evaluate the management processes utilized by The United States Department of Energy, Office of Worker Advocacy, in processing applications for medical review of whether a worker's illness was caused, contributed to, or exacerbated by exposure to a toxic substance out of and in the course of employment at a DOE facility.

The Office of Worker Advocacy is faced with a difficult challenge in processing an unexpectedly high volume of applications from former Department of Energy contract workers. The large number of applicants seeking qualification of their exposure to toxic substance speaks to the success of the Office's educational outreach efforts thus far.

As outlined in the Statement of Work, our goal was to provide process improvement recommendations designed to enhance the efficiency of service delivery. The purpose of doing so is to clear the existing backlog of cases and put procedures in place to allow for increased future production. To accomplish this objective, we focused on three primary deliverables:

1. Review of the current OWA workflow process, with commentary on whether the process is reasonable based on accepted claims industry best practices. Utilizing this information, we have identified duplications of effort and made recommendations for improved procedural efficiency, which we believe will reduce or eliminate bottlenecks through process design changes.
2. Review the function and responsibilities of each OWA staff position to identify staff role efficiencies.
3. Evaluation of the existing data management systems (CMS) with recommendations for enhancement.

Recommendations are organized by process flow and then further identified into three categories. Key recommendations that we have made address the following categories:

1. **Organizational Recommendations** – Includes a recommendation to shift the burden of proof to employees and contract sites, along with suggestions for revamping the claims data management systems.
2. **Internal Best Practices Recommendations** – Key recommendations include consolidating the file building duties.
3. **Structural Recommendations** – Key recommendations address responsibilities of various job classifications, and possible additions or reallocation of staff resources.

Executive Summary

The second phase of this study will address each recommendation and prioritize them to ensure the most effective improvements, as well as suggest a timeline for implementation. Hays will incorporate an action plan for each recommendation, in order to meet the immediate goal of transitioning the production rate of 45 cases per week to the target of 90 cases per week. We will present this future portion of the project in written and graphic format, utilizing tools such as Gantt charts and project planning software.

If the proposed changes are implemented, we are confident that the OWA will ultimately see:

1. Improved allocation of resources.
2. Effective communication
3. Elimination of case backlog
4. Timely determination of benefit entitlement
5. Increased program capacity
6. Decreased operational costs

Hays submitted draft versions of this report to OWA for review and comment on September 15, and October 13 2003.

Methodology

Our report and recommendations are based on observations and experience with a multitude of other claims and regulatory operations, combined with general operations management principles. In order to accomplish the goals of our review, we completed the following steps:

Interviews

- In an effort to understand the major aspects of current OWA procedures and policies, Hays Companies visited DOE headquarters twice in August. We conducted interviews with approximately 15 OWA staff from DOE and contract administrators. These represented a wide range of responsibilities and roles including; case managers, policy staff, records, quality control and mailroom staff, staff physicians and others.

Interviews lasted from thirty minutes to an hour and a half, depending on the depth of information. The scope of the interview process was limited due to the time constraints and unfortunately could not encompass the full perspective of all stakeholders.

It should be specifically noted we did not have speak with panel physicians, Resource Center staff or Record Managers at DOE facilities while conducting our program review.

Written Material Review

- Visits and interviews were completed only after Hays staff had an opportunity to thoroughly review the procedure manuals and other available documents provided by DOE and contract staff. We reviewed program statistics, rules, flowcharts, written reviews and applicant case files.

Information Systems

- We had the opportunity to review the Case Management System during various phases in the OWA process. We were able to navigate around and do some basic functions on a few cases and got further impressions of system functionality by observing case management and other staff utilizing the system while we met with them.

Simply stated, the underlying problem of the OWA is that the program is a process driven model in which the demand for services exceeds the supply. For this reason, the methodology will provide the reader with analogies to supply chain management, in order to help identify and process bottlenecks.

Supply chain management is the process of managing the materials, resources and capacity of a process to successfully and efficiently deliver a product or

Methodology

service. In our analysis of the OWA program we will consider a product to be a fully completed Initial Physician Panel decision.

Materials

In the OWA process, we will focus on the medical documents, case information, employment information and other assorted records as the materials that are required to move the product through the process.

Resources

Documentation such as contracts with DOE contractors and resource centers are resources. The level and placement of staffing at the contract employers, at the resource centers and at the central mail, records and case management office are the resources for this process. Staff expertise and qualifications are resources that are utilized to process the information along the supply chain to the end result.

Capacity

Staff assignments and placement, along with the availability of the Physician Panels, can be considered as the capacity level of the OWA process. To a lesser extent, the amount and location of office space can also affect the capacity of an operation.

Demand

In normal supply chain management, there is opportunity to manage the level of demand through provision of incentive or barriers to access the process. Here, the management of the process must correctly and appropriately react to and adequately respond to the push and unfettered demand of the applicants who have presented with more than anticipated numbers to date.

As of August 29, 2003, there have been 18,823 benefit applications filed with the OWA program. Applications continue to arrive at the rate of approximately 160 per week. In February, the program management and staff committed to processing 100 claims a week, beginning in August 2003.

Since that time, the program has only been able to sustain a consistent case completion and referral rate of 30 files per week. Part of the delay has been due to staffing challenges, space and moving considerations. While the numbers are significantly divergent, we believe that a completion and referral rate of 90 – 100 a week is attainable and sustainable.

Methodology

Symptoms

As DOE was designing the system, they were simultaneously experiencing an increase in the demand for the service beyond what the planners and creators had anticipated. This occurred for a variety of reasons unique to a long public legislative process and the different versions of the program as it was being drafted revised and passed into law.

In addition to the symptoms we will detail below, service and delivery expectations were set to levels that applicants hoped for, but may not be met. One example was the hope (and continued belief by some applicants) that benefits would be provided once a determination was made. These expectations, although not realistic for the version of the program that ultimately passed, nonetheless will challenge the quality expectations and measurements of the program as it moves forward.

Backlog

The OWA program has received 18,823 applications since beginning in 2000. There has been increasing pressure and attention to process the backlog in claims. 14,400 claims await action for development and 2,800 are in the development phase at this point.

With the increased demand for the system and the design flaws in the process, DOE has made it a priority to reduce existing backlogs and produce a sustained level of production.

When making recommendations for the system, we can't focus on a simple amplification of resources in the existing process. When capacity and demands are changed along one dimension or area of the line, there are additional strains on other areas of the chain. This is known as an accelerator or bullwhip effect, and can serve to worsen the overall backlogs.

We are more concerned that, as resources are applied to push the backlog of cases from records to quality control, this will worsen the backlogs in the Data Acquisition Request (DAR), moving next to the case management process and more drastically in the end to the Physician Panel segment of the process.

One of the most effective ways to improve and remove symptoms in a supply chain management model is to reduce timelines and to make changes effectively to respond to changes in demand.

Overview and History of the Program

Overview

The Energy Employee Occupational Illness Compensation Program Act of 2000 (EEOICPA) Part D directs the United States Department of Energy (DOE) through the Office of Worker Advocacy (OWA) to help atomic workers with work related illnesses file claims for workers' compensation benefits from their state of employment.

OWA is responsible for creating and administering Physician Panels for the purpose of making determinations whether a worker's illness was caused or worsened by exposure to a toxic substance while employed at a DOE facility.

History

EEOICPA includes a number of congressional findings outlining the history of Federal nuclear energy work. The findings also outline the rationale for developing programs to address the decades of toxic exposure the Federal government and its contract employers exposed its employees to.

We have selected portions of those findings to provide some context for the Part D program we are reviewing and making process change recommendations for. The findings also serve to ground our recommendations to improve a system that will better serve the applicants, who are the focus of the entire program.

Since World War II, Federal nuclear activities have been explicitly recognized under Federal law as activities that are ultra-hazardous. Nuclear weapons production and testing have involved unique dangers, including potential catastrophic nuclear accidents that private insurance carriers have not covered and recurring exposures to radioactive substances and beryllium that, even in small amounts, can cause medical harm.

Since the inception of the nuclear weapons program and for several decades afterwards, a large number of nuclear weapons workers at sites of the Department of Energy and at sites of vendors who supplied the Cold War effort, were put at risk without their knowledge and consent, for reasons that were driven by fears of adverse publicity, liability, and employee demands for hazardous duty pay.

Prior to enacting the EEOICPA, the policy of DOE had been to litigate occupational illness claims, which deterred workers from filing workers' compensation claims and imposed major financial burdens for such employees who have sought compensation. Contractors of the Department have been held harmless and the employees have been denied workers' compensation coverage for occupational disease.

Overview and History of the Program

To ensure fairness and equity, civilian men and women have performed duties uniquely related to the nuclear weapons production and testing programs of the Department of Energy and its predecessor agencies, should have efficient, uniform, and adequate compensation for beryllium-related health conditions and radiation-related health conditions.

Under the Part D provision of the EEOICPA of 2000, DOE provides assistance for qualified DOE contractor and subcontractor employees in applying for benefits in their last state of exposure. State workers' compensation systems then handle the claims as they handle other occupational disease cases.

Creation of the Program

There are no monetary benefits associated with Part D, rather, it serves truly as an advocacy role in assisting applicants to create a case, receive a determination and essentially take it to the steps of their state workers' compensation agency.

This program was a conscious decision to not enact a federal mandate for states to approve and accept claims. DOE and the federal government were very cognizant of the states rights issues unique to the workers' compensation models in each jurisdiction.

There remain many who believe a direct benefit program (similar to Part B) would be a better option for dealing with these cases. Indeed, many applicants and observers still mistakenly believe there are benefits paid after a determination.

Without benefits attached to the findings, the current system has some inherent flaws, in that it creates an enormous and lengthy process in order to reach a determination, which must then be submitted to an entirely different jurisdiction.

Upon receipt of a determination for eligibility, the program issues a type of stand-down or cease and desist order to its contract employers to not affirmatively defend the cases in the state dispute resolution system.

DOE chose to run the program with a combination of DOE staff, contract staff and temporary help. The benefit to the current staffing is the flexibility it offers for moving and reassigning resources on a relatively short timeframe. We believe this flexibility will enhance the application of system design changes and make our recommendations more manageable and easier to implement than if all staff were DOE employees with rigid position descriptions.

We believe a better program design would have been a hybrid; combining intensive records compilation with more typical workers' compensation claims roles for case development and management, consulting with medical professionals at the referral stage.

Overview and History of the Program

The program as designed requires coordination and cooperation from other agencies – NIOSH and the Department of Labor for both dose reconstructions, and for provision of Physician Panel doctors.

This required cooperation adds additional system challenges and delays, as often other Federal Departments do not have the same priorities and responsibilities to the program as DOE. Continuing to focus on the cooperation and data sharing between the OWA program and the other agencies is critical to the success of this program.

OWA Process Review

In May 2003, the US Department of Energy adopted a 107-page procedure manual with detailed processes, forms and addendums. Additional workarounds and adaptations have occurred in the system prior to and after the adoption of the procedure manual.

The second phase of this report will review the actual procedure manual to determine if current processes follow the procedure manual, and if not, whether they should follow the manual more closely. While workarounds and adaptations may be necessary, they also can tend to lead to additional backlogs and delays in unintended places as resources are constantly shifted from addressing one crisis to the next.

Hotline and Outreach

DOE and OWA have conducted numerous outreach and town hall meetings in order to help inform potential applicants about the program. These efforts served a valuable role by allowing public airing of concerns and complaints about the long-term impact of exposure to toxic substances.

OWA was wise to establish a toll free hotline to take initial calls, answer commonly asked questions and serve as an interim intake path for applicants. Until the program was up and running, the hotline staff acted as the face and voice of the program to applicants. This was and remains a valuable function for the OWA. Even as the call volume has dropped and more of initial information intake processes are handled at resource centers, this function provides a valuable service to applicants.

The Hotline function currently has a staff of two, with a supervisor. The Hotline staff act in an advocate role, providing information for the EEOICPA program. They are able to take new applications over the telephone. They also take many status calls on pending and in process cases.

While originally designed to provide a script and reference sheet for frequently asked questions, most hotline staff are seasoned enough to answer questions without the aide of a script.

Intake and Application Completion and Filing

Energy Employees Compensation Resource Centers are located in the field, close to contract employer locations in:

Anchorage, Alaska
Espanola, New Mexico
Idaho Falls, Idaho
Las Vegas, Nevada
North Augusta, South Carolina

OWA Process Review

Oak Ridge, Tennessee
Paducah, Kentucky
Portsmouth, Ohio
Kennewick, Washington
Westminster, Colorado

Resource Centers are jointly run by DOL and OWA and serve multiple functions including an initial intake location and as follow-up coordinator for obtaining personal medical records from applicants. The Centers serve as another face to the public for many applicants and their role is important to the OWA program. Resource Centers also assist with communication and in obtaining records for applicants. They can serve as a central records deposit center in the field for those workers living near the Centers.

Once applicants obtain a form, they need simply fill it out and submit it to the DOE for intake and processing.

The mailroom is the first headquarters stop in the OWA process. Mailroom staff receives all incoming mail, logs each piece of mail and batches for file department. The mail is logged in an Excel spreadsheet.

The Quality Control (QC) team consists of five staff with a team lead. Each staff is responsible for reviewing and processing 125 cases a week. We believe this is an adequate rate for two staff to process and open the 250 new cases that are received each week.

That rate also allows three staff to process 120 backlogged cases per week for a total of 360. At this rate, this will reduce the 14,400 backlogged cases to near zero within 40 weeks. Quality Control is responsible for determining whether all information and case identification (Name, Social Security Number, Work Location) is accurate and present in the case file.

They are the first step responsible for pushing on the backlog, and as such, will have an enormous impact on how quickly cases are taken out of a waiting development stage and moved to the case development stage, which will start pushing the capacity of other areas farther down the process. QC team reviews cases then places into a case management queue where they are worked first in first worked order.

Case Documentation

Record gathering is performed by a combination of staff in the records, case management, quality control and with the contract employers in the field. Case management team staff is responsible for completing and responding to a Data Acquisition Request (DAR).

OWA Process Review

The DAR is filled out by case management staff and sent to the field for securing and providing documents employment and health monitoring records where available. Once those records are secured, they are sent back to OWA headquarters and processed as records at the mailroom. Upon receipt, a note is sent to the case management team notifying them records were received on a specific case. The records are then batched and moved to the records room where they are placed in the case file until retrieved by the case management team. It is the applicant's responsibility to obtain all medical support for claimed injury/illness

The case development process depends heavily on the performance of contract employers, other agencies and outside vendors. The OWA is awaiting a number of NIOSH dose reconstructions for cases to move forward. These are labor and time intensive, but will greatly enhance cases once they start coming into the program. There are more than 300 reconstructions pending longer than 300 days from NIOSH.

OWA DOE staff have focused to some extent on ensuring contractors are performing up to expectations. Despite oversight and pressures, many sites are still experiencing delays in providing requested records in excess of 60 days. Many sites are still not providing records more than 300 days after initial request.

Case Management and Development

Claims are received via the hotline, resource centers, or mailed into OWA headquarters. Effective May 2003, if supplemental records are requested and not provided after 30 days, they can move the case forward to the next step in the process.

Case Manager (CM) nurses analyze available data. Supplemental records are requested by Case Management Assistants (CMAs) or Case Manager Technicians (CMTs). When received, these records are stored in a separate supplements records area in the file area. Staffing consists of 10 case managers, all with RN backgrounds. Recently, four CMT positions were created for the purpose of assisting in data collection and case organization. CMTs will be assigned to the CMs on a rotating basis.

The CMT role will be valuable and reduce some of the demands on the CM and enhance the CM productivity. CMTs generally are also responsible for looking at the injuries and diseases claimed and determining what additional information is needed. CMTs also compile occupational histories, which contain employment profile and past medical history. The CMT role also performs another QC by calling the applicant and answering questions. Finally, CMTs follow cases for receipt of follow up information and develop case.

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CMs were initially assigned cases based on site locations. The original CMs have a higher caseload than newer CMS but that difference will dissipate once new CMs build in more cases. Each CM is assigned 15 new cases per week.

CMs assign voluntary case reminders or ticklers that come up for future actions. These are not generated automatically and depend on the CMs to manually set them. Enhancements to the Case Management System may be valuable in helping to automate the management of the process in the case management process.

There are no case action plans or plans in place for individual cases. One lesson that can be learned from a workers' compensation claims operation is to create a case management plan and work the plan to enhance performance.

Completion, Case Highlighting and Referral

After the case management team gathers all pertinent records and documentation, the CM presents cases to the staff physician. A highlight of the case, prepared by the CM is made and used as an overview for summarizing the case to the Staff Physician and for review by the Physician Panels. Staff Physicians act as gatekeeper function for cases to go to Physician Panel. The stated goal for each CM is to complete and present five cases for Panel review each week. If that goal were met, the team would average 50 per week. In fact, the averages have been closer to 30.

Staff Physicians act as resource on disease identification and recognition, provide Case Managers and other staff medical training sessions. Staff physicians have also been helpful in creating the format for the case highlight area and working with the CM teams to understand the needs for file set-up and ordering for files.

As with the Case Manager role, we do not believe there is any reasonable justification for physicians to participate in the case compilations and records request process. Rather, with the increase in cases that will be coming through the process very soon, they need to take a step back, review the case highlight report with the CM and pass it on with the least amount of documentation possible for a positive finding.

Chart organization is important and needs to be done correctly. OWA staff should be cognizant that chart organization should not be the overriding goal of the case documentation process. While it is important for the presentation of the case to the Physician Panel, it is likely they will rely much more heavily on the case highlights which should have easy reference to documents and page numbers during the case highlight process.

OWA Process Review

Once a CM feels a case is developed and complete, it is sent to the staff physician for review. Cases take 2-3 hours to create highlights.

We believe this area poses the largest system delay and will be focusing some of our most important recommendations on streamlining and improving the supplemental records gathering and case development areas of the process. We believe making improvements in this process area will bear the greatest fruit if implemented.

Physician Panel Review

The National Institute for Occupational Safety and Health (NIOSH) is responsible for developing a roster of qualified physicians for staffing Physician Panels when requested by DOE OWA program.

There are 123 physicians, not all occupational disease specialists, on the roster from which to draw panels. Panels are chosen and created on a virtual basis for a one-year period of time. One of the largest challenges in this area of the process is getting the physicians to commit to staff a panel and make determinations.

Only 106 Panel Physicians are currently assigned to panels at this time. Once a panel receives a case, they have 30 working days to complete the finding and can ask for a continuance at any point in the determination process. Since the Physicians volunteer to be included on the roster there is limited leverage that the OWA program and Panel Administrator can apply on the Physicians to increase the number of cases they handle.

The Administrator has recently taken the step of attempting to match the availability of the roster physicians so that capacity is better matched for the one-year panel appointment.

Virtual Panels mean that physicians never necessarily meet in person but instead perform their work via electronic correspondence, telephonic conferences and sharing drafts back and forth.

Panels have a format in which to draft their determinations. Correspondence and ongoing information is mailed from the OWA to Physicians on the roster to keep them apprised of developments in the program.

Creation and operation of the Physician Panels required Federal rulemaking under provisions of Administrative Procedures Act. Non-DOE physician panels determine whether the illness or death that is the subject of the application arose out of and in the course of employment by the Department of Energy and exposure to a toxic substance at a DOE facility.

OWA Process Review

The design of these panels was based on the Fernald II Workers' Settlement Fund, which required a three-physician panel to provide neutrality and provide for a majority finding. Taking out individual physician bias or providing a strong willed physician to influence the opinion of another on a two-person panel is a noble goal.

This standard of proof is much lower and more liberal than most state occupational disease criteria. The fact that an applicant can make a "claim" of illness without definitive medical proof actually shifts the initial burden of proof from the applicant back to the employer (or in this case DOE.)

This is unique in a disability determination or benefit delivery system throughout the country. DOE and its contractors are then responsible for providing every pertinent medical and employment document to the panel in order to shed as much light a possible on the causative nature of the illness.

Findings and Recommendations

Our recommendations, while concentrated in different areas of the process will focus on reducing backlogs or bottlenecks we have identified in one of the three priority areas. We believe that focusing recommendations on areas identified as bottlenecks will leverage limited resources and time, to create the most significant improvements.

We believe that the following areas will experience the most significant impact in process changes; Records Retrieval, Case Management and Physician Panel Operations.



General

Failure in not meeting the goals of the program should not reflect poorly on the staff or their management of the program. We found the staff working in all areas of the OWA process to be dedicated to their roles, willing to work hard and to stay focused on their tasks as they were designed.

We believe that by focusing on the system, staff will be further encouraged to cooperate and coordinate among all members to help remove silos and segregation of responsibility that invariably happen with complex processes such as the OWA.

Changing production expectations in the current process, while important to keep focus on the overall goal, generally do not have the desired impact of increasing overall cases presented to the physician panel. We believe all staff are interested in making the necessary changes to help the program succeed in moving cases forward in a timely manner.

Findings and Recommendations

Case Management System Recommendations:

The Case Management System (CMS) offers file tracking and note functions for the entire OWA process. We believe a commercial off-the-shelf claims management system would have provided more immediate and valuable service for the program during the initial design phase.

Multiple recording, tracking, case timeline management, diary and reporting functions are available through existing off-the-shelf claims management systems. Many of these systems provide basic case management functions and reports at individual case manager, team, or overall program basis. These systems can gather information from multiple sources and provide meaningful metrics and program reporting functions.

After an initial survey of eleven claims management software vendors utilizing 30 case management users with a population of 20,000 cases, initial acquisition pricing indications fell in the \$50,000 range.

CMS was originally designed to support online document management, with basic case tracking. It does not appear to provide all the functionality contained in a standard case management system. CMS may contain custom functionality designed to support the EEOICPA process that is not available in commercial systems. Although we believe other systems could have been more effective, the current process is too advanced to benefit from a complete restructuring of CMS.

We understand a number of identified enhancements will be made to the system in October 2003. Additional enhancements are being suggested and tracked for future enhancements, which we understand will occur at regular six-month intervals.

*1) We suggest enhancements be made to CMS to: a) Improve navigational features to aid case processing, b) Add a tickler/diary system C) Create a more robust Ad Hoc reporting system to aid tracking program metrics. **Organizational***

Hotline and Outreach

The Hotline and Resource Centers continue to serve as the main information sources for the EEOICPA Program. At the present time, the hotline receives many types of inquiries, but the majority pertains to the status of the applicant's case. Throughout our interviews, there seemed to be general sense of importance for both the Hotline and outreach.

Findings and Recommendations

2) *Utilize Resource Center and Hotline staff with Information Gathering: The Resource Center and Hotline staff could be better utilized in the information gathering process. If the Case Manager provided an accurate posting of the necessary information, Resource Center Hotline personnel could relay this to the caller to expedite the process.* **Internal Best Practices**

3) *Collaborate with Hotline Personnel in Processes: As the Resource Centers and Hotline are the main resource for applicants to contact OWA, they should be informed of new initiatives that could affect the volume of calls, inquiries or other case-related activities.* **Internal Best Practices**

4) *Suspend the Traveling Outreach Centers until the current program backlog is eliminated. Due to the current backlog of cases, it would be prudent to temporarily suspend the traveling outreach centers until a grasp on the backlog can be achieved. By continuing the outreach, this just adds to the backlog and ultimately creates unhappy applicants where they just sit in the queue.* **Organizational**

5) *We suggest sending a mailing when QC has been completed on a case . This would also serve as a valuable notification to the applicant that progress is occurring on their case.* **Internal Best Practices**

Intake and Application – Mailroom

As we conducted our interview of the mailroom personnel, it became apparent that the entire process was over-complicated and cumbersome. It is the current practice to log each piece of mail and sort by types of correspondence. Each correspondence type is batched and sent to the file department for further handling.

We also discovered during our interviews that the mailroom utilizes a unique tracking system for each piece of correspondence. This tracking system is exclusive to the mailroom and does not correlate to the CMS system. This requires additional data-entry effort and creates unnecessary steps in the process.

6) *We recommend prioritizing and working on cases where applicants are still living and address them on a first in first acted on. We do not believe the process should hold up referrals of other cases, pending completion of earlier cases.* **Internal Best Practices**

Findings and Recommendations

7) *Rather than utilizing a batching process, we recommend that each piece of mail be aligned with the actual case. This indexing process will allow the File Department personnel to easily match the correspondence with the correct claim.*
Structural

While CMS contains a record of all previously received cases, it would seem duplicative to house a correspondence database. We believe that the use of an additional database adds unnecessary steps to the process. While indexing the mail, the mailroom personnel could create an alert for the Case Manager that new correspondence has been received pertaining to a specific case rather than forcing the case manager to look at a batched mail log to determine if mail has been received.

8) *Consolidate the two databases that are now kept separately in the mailroom and the records room, as they cannot relate to one another. Combining these in an ACCESS database, or more usefully, in the CMS, would improve the usefulness of this information for all staff.*
Organizational

Records and File Room Operations

The Records department is charged with custody and control of all case documentation. They must provide a secure environment for all records, pursuant to the privacy act. While personnel in the file department are adhering to this responsibility, we discovered that there are several process inefficiencies. The File Department utilizes yet another standalone database for file tracking, which does not offer CMS collaboration. This causes for duplication in data-entry and unnecessary steps in the process. We also discovered that the correspondence received from the mailroom does not meet-up with the file until the case manager requests the file.

9) *Records staff have suggested, and we endorse, the concept of implementing a simple barcode tracking system for cases. These could be placed in each office and would facilitate the movement and tracking of files and reduce the need to spend valuable time and resources on tracking down and finding files. Case tracking will be even more crucial as the push to move more files increases in the next few months. Barcodes based on social security numbers could automatically update the CMS relatively easily.*
Structural

10) *Eliminate the separate and unique case record number for each application case. Creating a separate number creates confusion and can lead to one more area for mistakes to be made. Rather, the last two or four numbers of the social security number may be a more efficient way to store the records. This will allow for more flexible file storage than the current state specific / alpha system allows.*
Structural

Findings and Recommendations

Even if the unique case file number system continues, we recommend filing should be done by utilizing the last two digits of the case file number, or alternatively, utilize the last two digits of the social security number to preserve confidentiality. The current filing and records storage method is inefficient and prone to creating confusion.

11) *Eliminate the supplemental file room and consolidate those records in with the regular case records. **Structural***

12) *We believe that the file department could utilize the CMS system for file tracking. Every electronic file should have a paper file, which would make tracking paper files location easily done in CMS. By adding a status on the whereabouts of the file in CMS, this would eliminate the need to use another database to track the file. While we recognize this is a system change recommendation, it would eliminate the need to house similar data in two different places. **Organizational***

13) *Records section should create a records recovery process to deal with lost files. This will become more of an issue as more cases are pushed through the process. **Structural***

14) *We recommend that all correspondence received from the mailroom be immediately placed in the main case file. The process whereby placing correspondence in a "temporary file" adds to the possibility of lost or misfiled correspondence, not to mention an unnecessary step by handling the mail two or three times in the file department. **Structural***

Quality Control

While the Quality Control (QC) area is not one of our three critical backlog areas, we still see some areas where a process change can enhance the system at this point.

The QC section performs the initial file assembly and provides for the initial check for missing information such as a signed medical release. The QC personnel also perform a simple file assembly into major correspondence types. Due to the significant backlog in the QC process, we have identified it as the first of three constrictions in the overall process. Although this constriction is important in itself, it is the lowest in priority, as it has not directly affected the Case Management process.

We believe there are significant opportunities for decreasing the timeline of the records request and provision area process and in-turn decreasing the entire process by focusing on shortening the process in this area.

Findings and Recommendations

This process is not really a pure claims investigation process. Rather, it looks and acts more like a record recovery process. As such, we recommend staffing be more focused on clerical record retrieval roles and less on the medical side at this point.

15) *Eliminate applicant cases that have lifetime 0% exposure to toxic substances. This can be performed at the QC level with assistance from CMT.*
Organizational

16) *We recommend an immediate and complete case audit process occur on all 14,000 pending “cased development” status cases. Determinations could be made relatively easily to provide ineligible determinations and also to move forward cases that need more information and process immediately, or move forward fewer numbers of cases for development.* **Internal Best Practices**

17) *During the audit we suggest eliminating some of the applicants by re-contacting them to determine A) are they still alive, B) are they still interested in pursuing a case?* **Internal Best Practices**

18) *We recommend utilizing QC personnel in the initial records gathering process. Typically the applicant provides notice of sites worked. In this case, the QC personnel could mail a Data Acquisition Request (DAR) for employment and any other site-specific information. This would decrease the time it takes for the initial request and increase the receipt of site records.* **Structural**

19) *Cross-train the QC staff with mailroom functions. The process already utilizes this timesaving method somewhat and could benefit from the practice more so. The knowledge and skill sets required for many of the processes in the records management area.* **Structural**

20) *We recommend medical and other releases be initiated by Quality Control if they have not already been provided at initial application. Especially with backlogged cases awaiting action, we recommend the QC function send out requests for information at this point when they look at the backlogged amounts.*
Internal Best Practices

Case Development and Document Acquisition

21) *The stated timeline for developing a case is 120 days. We believe this time, although not currently being met, is too long for records gathering. With the additional monies available to the site contractors and the experience they are obtaining, shortening this to 90 days is more reasonable.* **Organizational**

Throughout our interviews, we heard that the main challenge to the case development process was the gathering of necessary medical, employment and

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exposure data. We determined that the main source of delay rests in the requisition of records from DOE contractor sites.

We have identified the case development process as the second bottleneck in the OWA process. This bottleneck is considered the most critical as it leads to significant backlog in case processing. We have identified three main parts of the case development process: Document Acquisition, File Organization and Case Summaries/Highlights. We will provide greater detail into each process below:

The entire process relies heavily on areas it cannot very well control. The most effective way to control the timeline is to institute performance standards and monitor compliance from contractors.

22) We recommend that there be a sliding fee reimbursements or incentives for contract employers to provide records in a timely manner less than 60 days.

Organizational

23) We recommend performance penalties for site managers that have been contacted and continue to lag on providing records. Putting more teeth and consequences in place for non-cooperation would enhance the document provision and shorten the timelines. **Organizational**

24) Set timelines for each step in the process on the case status (Open, FILENOWA, QAREQC etc...) create a list of cases that exceed minimum acceptable standards and focus on moving those forward. **Internal Best Practices**

25) In general, look at using Just in time scheduling so that cases with the most up to date and complete supplemental medical records get attention first and moved on to the Case Management process. **Internal Best Practices**

26) We recommend Resource Center personnel play an increased role in the requisition of data from both DOE Contractor sites and applicants. As the Resource Centers are geographically situated near most DOE Contractor sites, they should act as the Field Data Acquisition Specialist. **Structural**

As the field specialist, if delays are seen in gathering data, they can act as the liaison to work with the local DOE Contractor to expedite the request. It is also felt that if an application originates from a Resource Center, the resource center personnel should complete the initial document acquisition request (DAR) to further expedite the process.

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27) We recommend that record retrievals concentrate on those sites that have the most outstanding applications (Paducah, Rocky Flats, Los Alamos, Savannah River, Oak Ridge and Hanford) are located in those states that have the most complete agreements with the DOE or have the most complete records. Alternatively, we recommend sorting claims by contractor or state and continuing the case development with consistent assignment to CM teams based on location. **Organizational**

28) Another way to shorten the process is to select all cases awaiting a determination from other programs (Part B) and put in abeyance until a decision is made. This would put burden on other programs and free up resources to focus on remaining cases. This may significantly reduce the number of cases that are entitled to Part D findings if there is a presumption on Part B determinations. **Internal Best Practices**

29) We recommend a shift of the burden back to the employee when there is little or no known medical causation with a “medical degree of certainty”. This higher standard could significantly reduce the backlog by eliminating cases that won’t likely be determined eligible at the end of the panel process. **Organizational**

While this will present a major shift in the burden, we believe the overall benefit to the program for reducing backlogs and improving the timeliness of case processing and panel determinations to the remainder of the population more than justifies this change.

There remain innumerable opportunities for claimants to revive claims through provision of additional records or requesting appeals of decisions at almost every level and step of the process. We believe there are ample opportunities for improving the timelines through eliminating more cases, while ensuring access to the program for the great majority of applicants who come to the program.

Case Management

We believe this is an area for great efficiencies that can benefit from some ongoing attention and focusing resources to more efficiently process applications and pass them on to the Panel Process.

We do not recommend the OWA process continue as a First in first worked process – rather we believe there is plenty of opportunity to get enough information in these initial audits to determine if movement forward is appropriate at ANY point would enhance the case.

There are several key personnel that perform vital roles in the case management process. We will discuss each role separately as each role is uniquely different.

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Nurse Case Managers

It became apparent during our interviews that the Nurse Case Management staff is being over-burdened with administrative functions. While we recognize that significant energies have been placed to build a strong Nurse Case Management Staff, their expertise could be better utilized.

We believe the medical attention is valuable but certain parts of the file documentation process could be performed at lower levels of responsibility (CMA or CMT) on the teams. Our observation is that Case Managers were responsible for too much of the actual case assembly and records requesting process. This is likely a holdover from when the initial process was implemented and there were fewer staff managing the process.

Case Summaries/Highlights

The process of case summarizing or highlighting provides an easy reference guide to the physician panel reviewer. We identified that the case highlights are nothing more than a file index or table of contents. We believe that this is a necessary process and were advised that it generally takes two to three hours to fully highlight a case.

We believe the CM plays an important and significant role in the highlighting process. With their medical knowledge and experience in disease recognition, they are better trained to review medical documentation and prepare a summary of the necessary information. By removing the daily administrative functions from the nurse case manager, they can focus on case highlighting, which will allow for increased case output to the physician panel.

If the Nurse Case Manager presently completes 5 cases per week utilizing 2-3 hours per case, their production rate could be increased to 10-15 cases per week with an average of 12.5. At the staffing levels observed in August, the nurses could complete 100 to 150 cases per week with an average of 125. This would more than achieve the goal of 90-100 cases per week.

30) We recommend that the nurse case managers be transitioned to a role of case consultant. This would allow the nurse case manager to review cases ready for panel assignment and create the case summary or highlights.

Structural

With this change, the Nurse will be freed from administrative functions that are consuming much of their time at present. As a consultant, the nurse will also act as a resource for case development and data acquisition, but not perform the actual requests or follow-up.

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31) Nurse Case Manager's should assist Staff Physicians in the creation of a Quick Reference Guide to allow for easy recognition of diagnoses and the necessary information needed to develop a case. **Internal Best Practices**

32) Once the OWA physician has approved the case as ready for panel, provide concurrent notice to both applicants and employers. If employers do offer something, notify applicants again. **Internal Best Practices**

33) Move cases forward for OWA physician review when all information is received, or after a certain number of days in the Case Management System (150 days for instance). **Internal Best Practices**

Case Manager Technician (CMT)

This is a newly created position, which was added to assist the Nurse Case Manager in the initial case development and data acquisition process. We believe that this position can play a significant role in the case development process.

34) We believe that the Case Manager Technician should assume the primary responsibility for case development. This includes determination of the necessary documentation necessary for development, utilizing the Nurse case manager as a resource. The CMT should also be responsible for file assembly and initial case highlighting. **Structural**

Case Manager Assistant (CMA)

This position is the primary administrative resource for the case management operation. While the CMA provides valuable assistance in the process, their role in the case management process does not need restructuring. It is our suggestion that a greater responsibility be placed on the CMA in the records gathering process such as tracking and follow-up.

35) We recommend the Case Manager Assistant act as the main requestor of data based on the recommendation of the Case Manager Technician and/or Nurse Case Manager. We also believe that the CMA should monitor all requests and provide the necessary follow-up as needed. **Structural**

Case management staff advised us the organization of the file is a time consuming process. There are more than 30 potential file section headers under which information can be placed. The file organization process has recently been refined by the OWA physicians, to ease in the physician panel review.

We feel that the file organization is necessary, however, it should be refined. We believe that minor subject data should be incorporated into major topic sections

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with indexing in the case highlights only if the data is relevant to the physician panel. Too much specificity and detail can lead to delays in compiling and moving files forward if time is spent on determining the appropriate section as opposed to working more files.

OWA Physician

We believe that the OWA Physicians play an important role in the process as they are invaluable resources to the Nurse Case managers in providing in-service training as well as acting as the final quality assurance check before the case is sent to the physician panel.

36) We recommend periodic roundtable or triage meetings with CMs and staff physicians to strategize and share information on unique cases and efficiencies.

Internal Best Practices

We understand Staff Physicians have already helped to create a list of illnesses and exposure links and also worked to help make the file creation and compilation more consistent between cases. This will enhance familiarity and ease of file review for Case Managers, and Panel Physicians.

Physician Panel Process

The virtual nature of the Physician Panel process naturally leads to delays in reviewing and completing determinations. Since parties do not physically meet there are delays due to arranging for schedules, for sharing information, for drafting determinations and for choosing a lead physician to draft the finding.

We make some recommendations to enhance the process so Physician Panels can be more effective and productive over a shorter period of time. Reducing the delays inherent with the virtual nature of the panels is key to success of the program.

The referral to and ability of the Physician Panels to process applications and reach determinations have been a main area of backlog for several months, and these backlogs will continue to grow if no changes are made to the process. As the push for cases comes through the QC, File Development, and case management processes, they will invariably wind up at the beginning of the Physician Panel Determination process.

37) We recommend Panel Determination reports be kept as standard and consistent as possible to reduce the likelihood of appeals based on administrative errors or omissions. The determination order could be available and preferably filled out on a force completion basis. In other words, when creating the order, certain data elements would need to be filled in before it can be successfully transmitted. Internal Best Practices

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This recommendation would assist the panel, the Panel administrator and reduce delays in the process. Steps have already been taken in this area and we believe even more stringent guidelines, boilerplate language and consistently formatted reports be adopted from the panels. Many dispute resolution and determination processes utilize consistent language when drafting findings and orders. The purpose is not to reduce flexibility for panel physicians, but rather to increase system efficiency.

This change will also assist the Panel Administrator role in expediting cases to HQ for approval and service to all interested parties. We received comments that the inconsistencies have led to delays in getting cases finalized with cases sometimes needing to be re-submitted to panels for clarification.

38) *We recommend increasing the number of doctors available for panel determinations through two methods.*
A) *Increase the reimbursement amounts to be more in line with the levels of skills required.*
B) *Request NIOSH more aggressively recruit qualified physicians for the program.* **Organizational**

39) *Enhance and improve the frequently asked questions and resources for panel physicians.* **Internal Best Practices**

40) *Prepare the file and have ready to go in queue for panel review immediately after the expiration of the 30-day notice period. (Just-in-time concept)* **Internal Best Practices**

41) *Notify Physician panel of pending cases and ship on the 30th day.* **Structural**

42) *We believe offering to have the physicians come together physically will enhance the production and efficiency of the Physician Panel process.* **Organizational**

43) *Another alternative is to arrange for and provide video conferencing techniques for physician panel determinations in the same manner as if they were in the same room. This may allow some cost savings over the DC conference solution.* **Organizational**

Bring multiple physician panels together in DC for extended periods. Provide travel hotel rooms and meeting space, meal reimbursements and clerical support staff for transcribing and producing the findings immediately.

We believe this process will also provide additional value to the OWA program by allowing program staff to provide education and in-service training on the referral,

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finding format and communication with OWA program staff. This will allow for more efficient operation of virtual panels in the future.

As an added incentive to encourage participation for physicians, provide CEU and medical education hours for the in-services. With the in-person panels, it would be reasonable to set production expectations of 5 determinations a day for a 10 -hour period. This would provide 15 in a three-day period.

Additionally, the findings would be almost immediately available for referral to the remainder of the process. If multiple in-person panels were running concurrently in the same hotel, OWA staff case managers and physicians could be available for questions and guidance. Additionally, support staff from the referral and finding processing area could have the referral packages available immediately after determinations were made. Signatures could be secured immediately from the physicians.

Case managers and other OWA staff could also learn valuable information from this process in that they could observe what the physicians look for once they are reviewing a case and could serve to provide further guidance to the case management staff for future case compilations and case highlights.

44) We also recommend the Physician Panel Administrator, Staff Physician, Case Manager (s) perform regular conference calls with Physician Panel doctors.
Internal Best Practices

As an alternative, we recommend longer term changes be made in the rules and regulations to eliminate the necessity for three physician panels.

45) We believe utilizing a single physician would be a better and more efficient way to reduce the timelines associated with coordinating work by the virtual physician panels. **Organizational**

While this may not be feasible, we believe the cost savings of using one physician, the increased number of cases that could be processed, this solution merits further investigation. Additionally, without since the backlog of cases will eventually present itself at the doorstep of the Physician Panel.

Further protection and safeguards are available in the process with ongoing multiple levels of appeals applicants can use in the unlikely event that there are increased proportions of negative determinations with the decrease in physicians making a decision. Indeed, 40% of the 74 cases that have had a determination were negative.

We can't conceive that a single qualified physician would find more negative determinations. Even with a slight possibility of an increase in proportion of

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unfavorable determinations, applicants still have numerous appeal and protection rights.

We believe the successful production of a determination is the best measure of success for the program, and certainly the outcome that applicants are awaiting for proceeding to the state workers' compensation system.

Based on the existing productivity levels, each panel physician on average devotes 12 hours monthly to reviewing claims. At current staffing, Physician Panel time is 1,272 physician-hours (106 physicians x 12 hours per physician.) The average review time per case is 12 hours (3 physicians x 4 hours per physician per case.) The maximum output is 106 cases per month.

If single physicians were able to do the determinations, the productivity could triple to approximately 318 cases per month, or 3,816 annually. The simplified logistics of having only one physician reviewer for each case could further increase output.