



# DLIR DCD Business Process Optimization & Business Case Project

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Workers Compensation Working Group Briefing

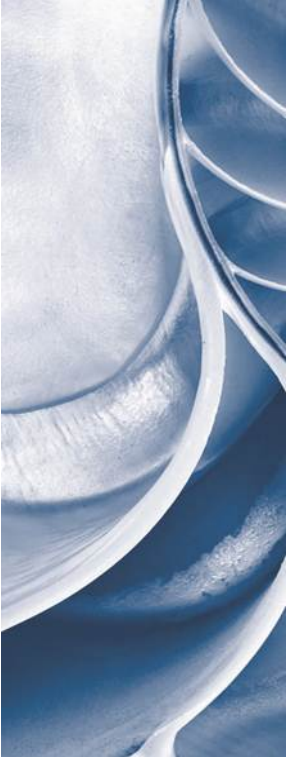


July 2016

## Meeting Agenda

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- Background/ Project Overview
  - Historical View
  - Role of DCD in Hawaii
  - DCD Workload
  - Key Challenges
  - Project Approach
- Part I: Business Process Optimization Analysis
  - Analysis Approach
  - Process-by-Process Business Process Optimization Analysis
    - Process Issues
    - Process Improvement Plan
- Part II: Technology Modernization
  - Key Challenges
  - Recommendations (Plan)



## Background/ Project Overview

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## Background/ Project Overview

### Historical View

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#### **Role of the State is to ensure protection and create an equal playing field**

- Employee Protection - WC is “no fault” insurance where employees aren’t denied coverage for contributory negligence and they receive wage replacement and medical care very quickly (rather than waiting years for the outcome of a tort)
- Employer Protection - WC is an “exclusive remedy” which provides employers relief from torts, reducing the potential legal settlement costs

#### **This “win-win” structuring led to it’s rapid adoption, in various forms, across all states**

- Some states act as the insurance provider and other states leverage a private insurance market:
  - Wyoming, North Dakota, Washington and Ohio governments act as the sole WC insurer
  - All other states, like Hawaii, allow companies to buy WC insurance from private carriers
- All states, including Hawaii, adopted a cheaper and quicker “quasi judicial hearing system” to mediate WC disputes
  - The benefit of this approach is greater transparency, efficiency, predictability and accountability

## Background/ Project Overview

### Role of DCD in Hawaii

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**The DCD's mission is to provide economic security and stability for Hawaii's workforce through education, enforcement, and adjudication of the WC, TDI, and PHC laws. DCD's objective is to get the injured worker healed and back to work as quickly as possible**

- Hawaii created the Disability Compensation Division (DCD) within the Department of Labor and Industrial Relations (DLIR) to administer the program laws
- In Hawaii, DCD has a critical role to play in oversight and enforcement of the program laws to ensure that average citizens' (i.e., claimants) rights are protected throughout the process
- Other critical roles include:
  - Enforcing employer compliance with WC, TDI, and PHC insurance coverage requirements
  - Managing funds that pay medical and wage replacement benefits to employees whose employers have failed to properly insure
  - Approving health plans to ensure employees are offered plans that meet the requirements of the PHC law
  - Processing of Certificates of Compliance for state contractors
  - Working with stakeholders (employers, carriers, providers, claimants, etc.) to improve the process
  - Tracking claims and injuries in the workplace for federal and state reporting and compliance requirements

# Background/ Project Overview

## DCD Workload

### **DLIR processes a significant amount of work; claims volumes have increased substantially over time**

- The WC, TDI and PHC programs are an important part of Hawaii's social insurance. Since the first WC law was enacted in 1915, these programs have grown in size and complexity every year and now support 600,000+ Hawaiian workers, thousand of providers and 30,000+ Employers
- As the size of the programs have grown, it has led to an equally rapid growth in the number of claims processed each year



## Background/ Project Overview

### Key Challenges

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#### **The workload increase of about 10% per year, together with the following factors has created a series of challenges**

- Processes are primarily **manual and paper-based** and has changed little in the past 30 years
- State budget deficits and attrition caused a **32% reduction in staff** (from 126 to 88), including the loss of an entire section, within a four year period
  - In 2008, DCD had 126 FTEs on staff
  - In 2009, 12 positions were lost, leaving DCD with 114 FTEs on staff
  - In 2010, the Reduction in Force cost DCD 19 additional positions, leaving DCD with 95 FTEs on staff
  - In 2011, an additional 7 positions were lost, leaving DCD with 88 FTEs on staff

#### **During this time, DCD also went through a long period of leadership vacancy before new leadership was appointed. In response to these major structural changes, the old leadership was focused on basic operations and could not focus on strategic improvements**

- Staff had to absorb multiple roles, often without formal training or role adjustments
- Role realignment was based on immediate needs without long term vision simply to continue operations and meet basic demand of getting employees back to work (e.g., investigators were assigned administrative/clerical work because of a lack of available resources)
- Oversight and compliance were not prioritized
- To compound matters, DCD took on additional duties during this time (e.g. billing disputes and processing of rapidly expanding requests for Certificates of Compliance)

## Background/ Project Overview

### Project Approach

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#### **DLIR now recognizes these challenges and is aggressively pursuing process optimization and new technology to improve efficiency and customer service**

- Given the financial realities of the State, DLIR is looking to business process optimization as a first step to realigning the organization through near term enhancements and to prepare for future long term modernization of technology
- Organizational changes will be critical to the business process optimization effort. Peoples jobs have changed substantially over the past 10 years and now include many duties not originally included. Job descriptions do not reflect the reality of work today. In addition, current alignment of roles within the organization limit transparency and span of control
- DCD Leadership do not anticipate or believe that there is a need to recover all positions lost during 2008 through 2011. To achieve the objectives, the focus is on business process optimization, organizational realignment and modernization of technology

**In recognition of these increasing demands on DCD and their programs, the Legislature provided a general fund appropriation for the Disability Compensation Program (LBR183) for fiscal year 2015-2016 to expend for business process optimization analysis and case management system modernization**



# Background/ Project Overview

## Project Approach

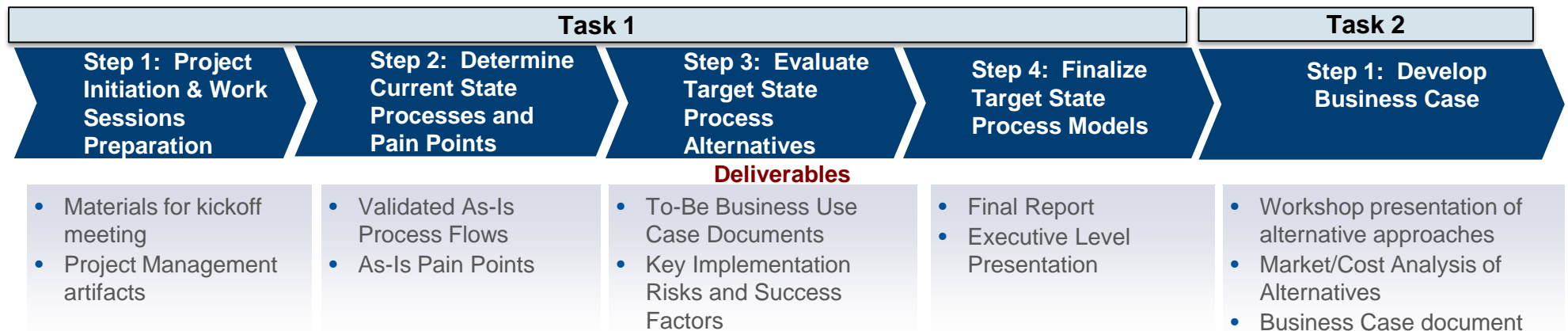
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**Based on guidance from the Legislature, DLIR procured consulting support to initiate a business process optimization project to identify the best path forward**

### **Critical activities included:**

- Brought in business process experts to help identify current efficiency issues, bottlenecks, outdated procedures, and data sharing challenges associated with DCD programs (WC, TDI, PHC)
- Conducted over 40 interviews (internally as well as externally with key stakeholders, like providers, carriers, employers, and claimants representatives) and multiple site visits to document over 30 current state business processes, examining all relevant statute and administrative rules that guide our programs
- Reviewed other jurisdictions to compare what others doing
- Met with the Labor Union to brief them on the finds of the assessment and potential future impacts on employees
- Conducted multiple rounds of workshops and review cycles in order to get to the heart of DCD's challenges

### **Project steps and deliverables included:**



### **As a result of the business process optimization effort, DCD has identified a series of key activities that can be taken to improve the organization**

1. The first steps address fundamental organizational structure issues and streamline current manual processes and procedures before investment in new technologies. DLIR must take steps to optimize processes without expending significant resources and to prepare for new technology. Key areas of focus included:
  - Rules changes
  - Legislative changes
  - Organizational changes (e.g., roles and responsibilities and accountability)
  - Process and procedure changes (e.g., minimize handoffs)
  - Analyzing stakeholder responsibilities and hold vendors (carriers, service providers) accountable for quality
  - In house training to improve standardization and quality
  - Establishing metrics (baselines) for ongoing continuous improvements tracking
2. Once the organization has successfully completed the business process optimization effort, the next step will be to complete a major system modernization project to address legacy system short-comings and risks, improve data quality, and eliminate paper-driven processes, improve customer self services, and automate manual tasks where possible



## Analysis Approach

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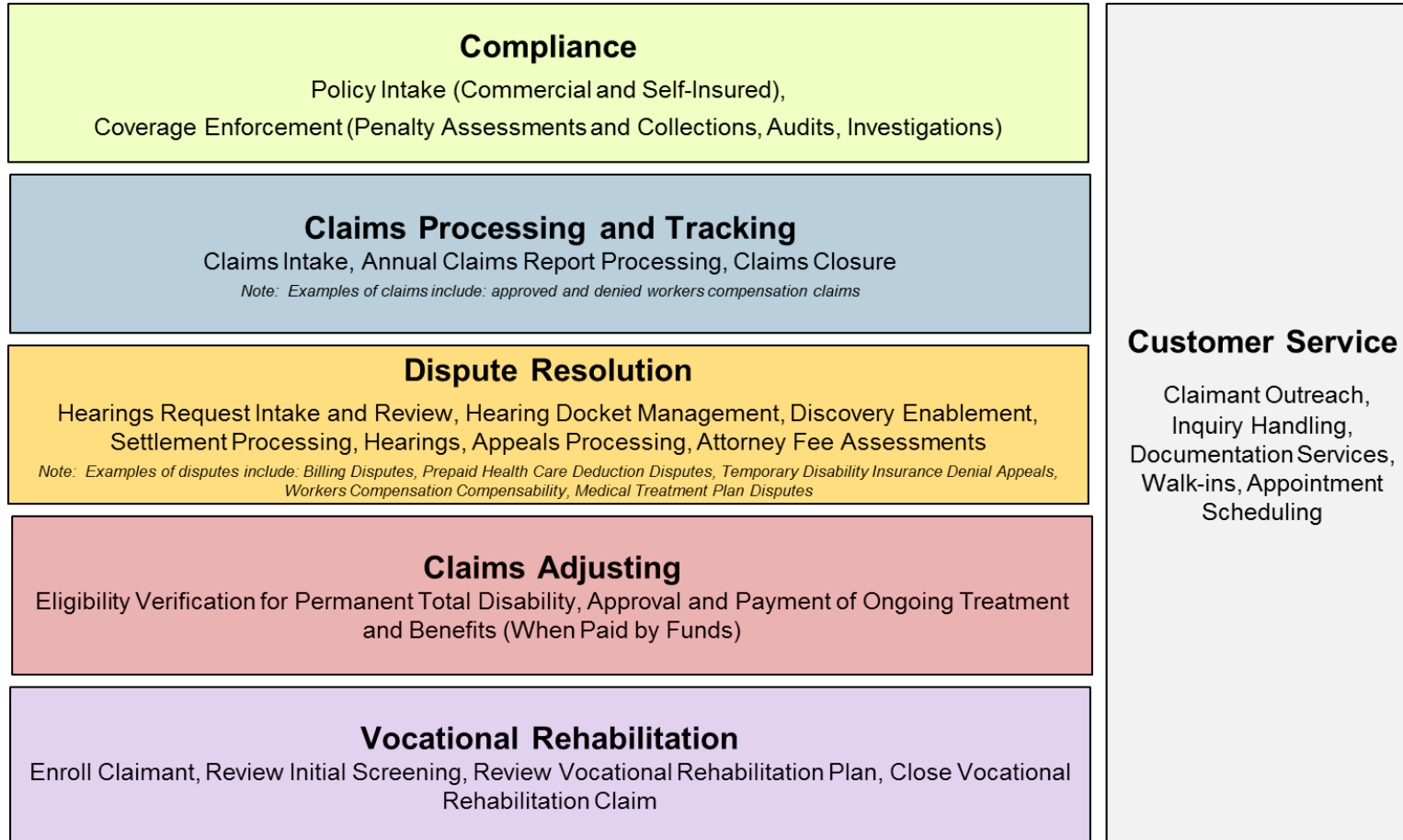
### Part 1: Business Process Optimization Analysis

# Business Process Optimization Analysis

## Analysis Approach

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We structured our analysis around these six process domains that cover the core parts of DCD's business.

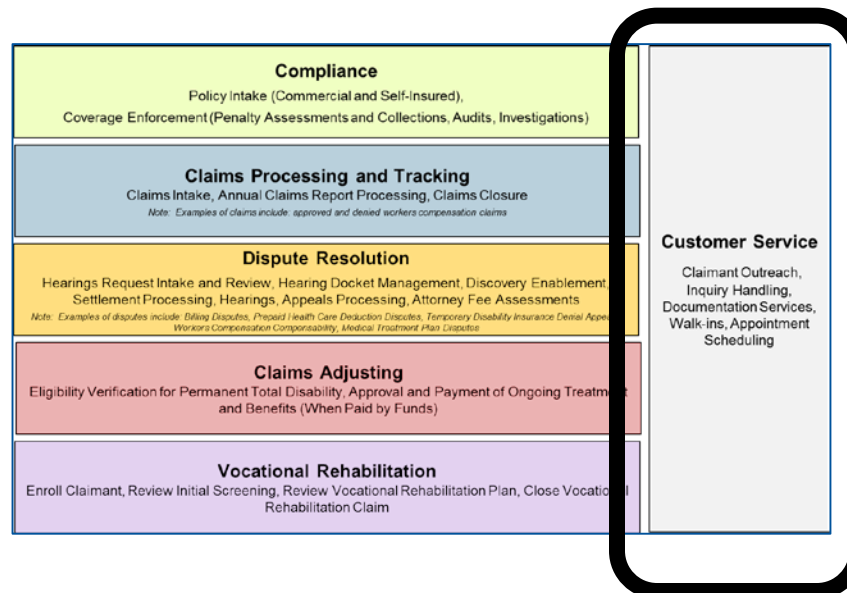


*The following sub-sections provide analysis of each domain including issues and improvement plans*



# Customer Service

## Part 1: Business Process Optimization Analysis



# Customer Service

## Key Process Issues

<b>Compliance</b> Policy Review (Operational and Self-Insured), Coverage Enforcement/Priority Assessments and Collections, Audits, Investigations	<b>Customer Service</b> Client Outreach, Inquiry Handling, Documentation Services, Waiver Agreement Scheduling
<b>Claims Processing and Tracking</b> Claims Intake, Annual Claims Report Processing, Claims Closure for Non-Operational Administrative Review/Revisions	
<b>Dispute Resolution</b> Hearings Request Intake and Review, Hearing Coordination Management, Claimant's Employment Satisfaction Processing, Hearings, Appeals Processing, Attorney Fee Assessments	
<b>Claims Adjusting</b> Eligibility Verification for Permanent Total Disability, Approval and Payment of Ongoing Treatment and Benefits (When Paid by Third-Party)	
<b>Vocational Rehabilitation</b> Client Contact, Review Initial Screening, Review Vocational Rehabilitation Plan, Create Vocational Rehabilitation Case	

### Inquiry Handling

- Each division and some branch's phone numbers are listed online, it's often unclear to the customer who he/she needs to contact
- No dedicated staff for answering customer inquiries
- Phones are often busy or calls are not answered when staff are away from their desks
- Poorly designed and outdated forms (which include limited instructions) results in claimants struggling to fill them out leading to back and forth contacts between the claimant and DCD
- Lack of customer relationship management tools and contact history increases time and repeat calls
- The current organization is not properly designed or motivated to provide customer service excellence; staff are not trained in handling inquiries (result of RIF staffing changes and lack of training)

### Claimant Outreach

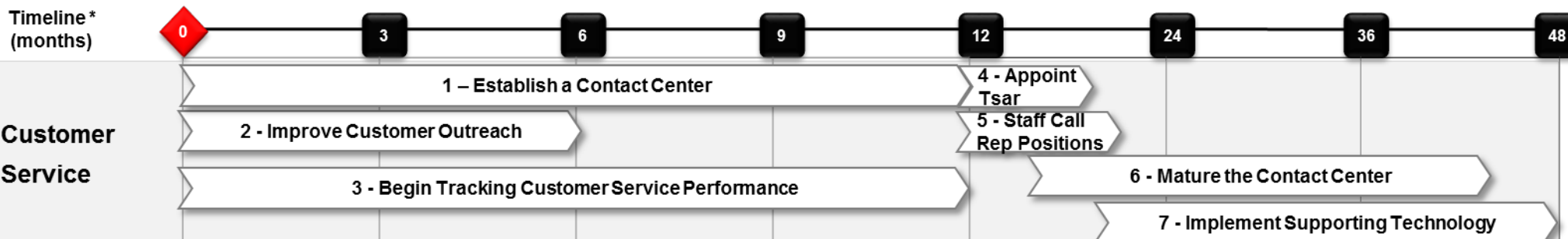
- Claimants may lose out on compensation opportunities due to lack of understanding of the process and failure to get needed support/education/information from DCD (e.g., addresses for outgoing mail often incorrect, there are 10-20 returned letters a day)
- Pursuant to HRS 386-71.6, the Facilitators' role was intended to provide higher level customer education and end-to-end claims support. With the staffing reductions, the Facilitators' role has been repurposed for clerical work limiting DCD's ability to support claimants throughout the process

# Customer Service

## Process Improvement Plan

<b>Compliance</b> Policy Work (Operational and Self-Insured), Coverage Enforcement/Priority Assessments and Collections, Audits, Investigations	<b>Customer Service</b> Client Outreach, Injury Meeting, Documentation Services, Waiver, Agreement Scheduling
<b>Claims Processing and Tracking</b> Claims Intake, Annual Claims Report Processing, Claims Closure	
<b>Dispute Resolution</b> Hearings Request Intake and Review, Hearing Coordination Management, Claimant's Employment, Settlement Processing, Hearings, Appeals Processing, Attorney Fee Assessments	
<b>Claims Adjusting</b> Eligibility Verification for Permanent Total Disability, Approval and Payment of Ongoing Treatment and Benefits (When Paid by Third-Party)	
<b>Vocational Rehabilitation</b> Credit Counselor, Reserve Rehabilitation Screening, Reserve Vocational Rehabilitation Plan, Case Inactive, Rehabilitation Case	

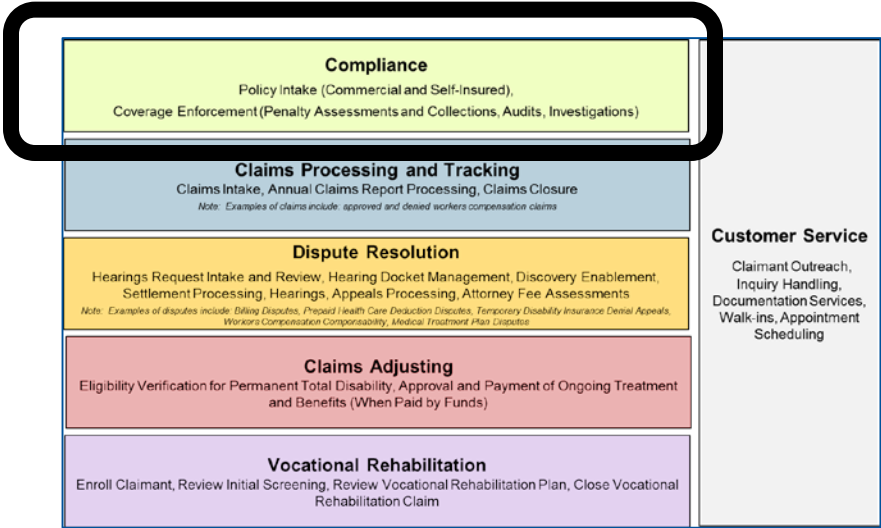
- 1. Establish a Contact Center** – create a cross-functional virtual team; use FAQs to drive consistency; update contact number to a Single Point of Contact and acquire a VoIP solution
- 2. Improve Customer Outreach** – utilize Facilitators for end-to-end claims support; update website, create new brochure and other hand-outs; redesign forms
- 3. Begin Tracking Customer Service Performance** – baseline performance to inform future improvements
- 4. Appoint a Customer Service Tsar** – establish accountability for maturing the Contact Center
- 5. Create and Staff New Permanent Call Rep Positions** – create new position descriptions for cross-trained professional service representatives for a permanent Contact Center
- 6. Mature the Contact Center** – establish separate organizational group; define two-tier support model; implement continual process improvements
- 7. Implement Supporting Technology to Improve Customer Service** – build a portal; expand electronic filing and Case Management





# Compliance

## Part 1: Business Process Optimization Analysis





# Compliance

## Key Process Issues



### Policy Intake

- Policy intake is an error prone and labor intensive paper-based manual process (with the exception of WC new and renewal policies)
- Insurers report policy data with missing or inaccurate data
- DLIR Unemployment Insurance (UI) owns Employer data and does not always make changes that DCD requires

### Coverage Enforcement (Including Hawaii Compliance Express (HCE) Requests)

- No link between Hawaii Compliance Express and DCIS or NCCI, resulting in manual validation and approval/denial of Certificates of Compliance
- DCD is receiving sole proprietorships to validate even though they do not require coverage
- Required financial audits of self insured employers are not being conducted on an annual basis due to staff shortage

### Coverage Enforcement (Continued) –

- No physical enforcement presence on Kauai, Lanai or Molokai with limited results in bringing delinquents into compliance (90% of delinquencies requiring a field visit are resolved with the field visit)
- Investigators tend to waste time traveling back and forth to the office because there is a lack of investigative tools in the field. Delinquent employers are assigned out to investigators and progress is tracked offline which makes it difficult to reassign work as needed
- Random compliance audits aren't being conducted due to Audit branch staff shortage
- Penalties for non-compliance are ineffective with low dollar amounts
- Investigations has limited authority to collect funds from delinquent employers; some cases end up written off after two years

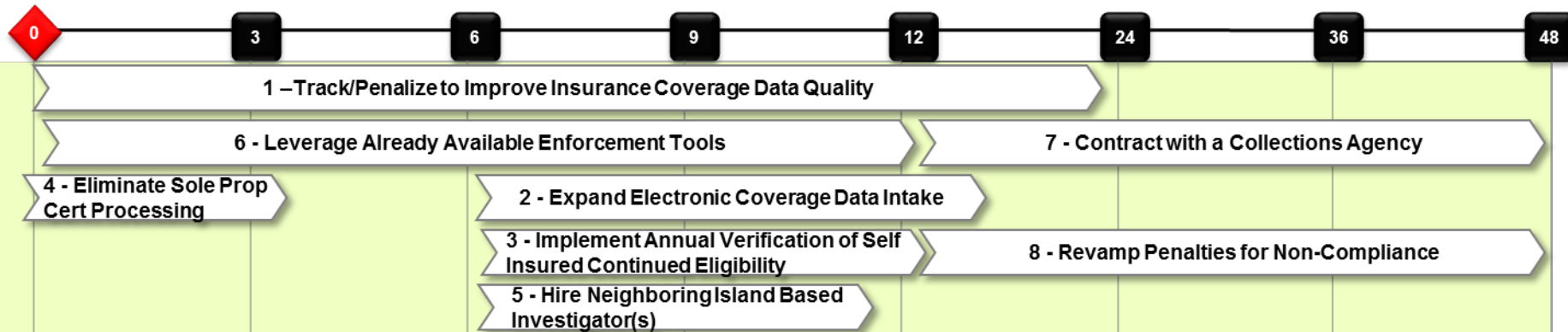
# Compliance

## Process Improvement Plan

<b>Compliance</b> Policy Work (Contractual and Self-Insured), Coverage Enforcement/Priority Assessments and Collections, Audits, Investigations	<b>Customer Service</b> Client Outreach, Injury Meeting, Documentation Services, Waiver Agreement Scheduling
<b>Claims Processing and Tracking</b> Claims Intake, Annual Claims Report Processing, Claims Closure for Non-Insured/Uninsured/Underinsured Drivers	
<b>Dispute Resolution</b> Hearings Request Intake and Review, Hearing Coordination, Claimant's Enrollment, Settlement Processing, Hearings, Appeals Processing, Adjudicatory Fee Assessments	
<b>Claims Adjusting</b> Eligibility Verification for Permanent Total Disability, Approval and Payment of Ongoing Treatment and Benefits (When Paid by Third-Party)	
<b>Vocational Rehabilitation</b> Credit Counsel, Reserve Rehabilitation Screening, Reserve Vocational Rehabilitation Plan, Close Vocational Rehabilitation Cases	

- 1. Track/Penalize to Improve Insurance Coverage Data Quality** – begin tracking data quality issues; meet with carriers to educate them on data quality challenges and persuade them to improve data quality; introduce penalties; put MOU in place with DLIR UI to address data quality issues
- 2. Expand Electronic Coverage Data Intake** – work with ETS to expand NCCI data extraction, or implement an electronic policy submittal on carrier-by-carrier basis
- 3. Implement Annual Verification of Self Insured Continued Eligibility** – identify and train staff to begin annual reviews of self-insured employer financial fitness for continued self insurance eligibility
- 4. Eliminate Certificate Processing for Sole Proprietorships** – work with HIC to improve HCE system
- 5. Hire Neighboring Island Based Investigator(s)** – increase physical presence on NI's
- 6. Leverage Already Available Enforcement Tools** – collect assessed penalties; use injunctions; complete random compliance audits
- 7. Contract with a Collections Agency**
- 8. Revamp Penalties for Non-Compliance**

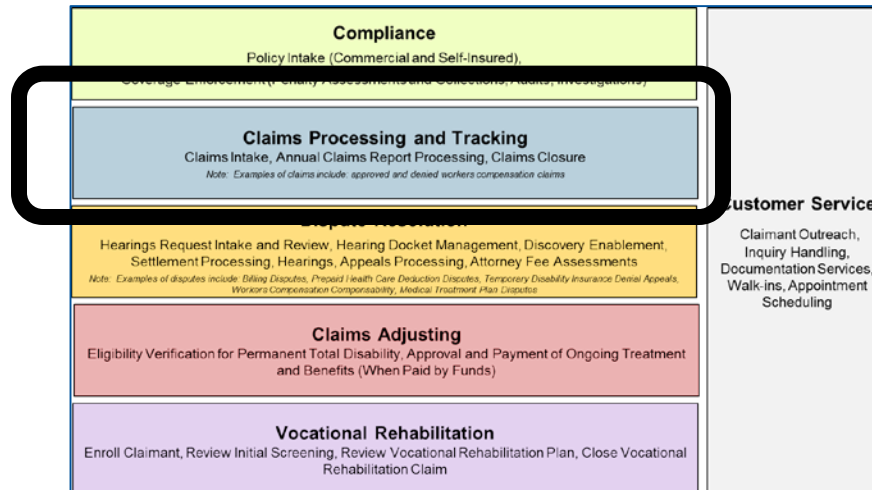
Timeline\*  
(months)





# Claims Processing and Tracking

## Part 1: Business Process Optimization Analysis



# Claims Processing and Tracking

## Key Process Issues



### Claims Intake

- Majority of Claims are reported using paper forms and process of dealing with paper is manual and error prone (claims get lost, misplaced, etc.)
- Only three carriers are currently able to submit claims (WC-1) electronically, and claimants are unable to submit electronically (WC-5)
- Carriers submit incomplete or inaccurate information
- Excessive amount of time to establish a claim (up to 8 weeks to establish a claim in the two separate databases). Until the claim is established it's not possible to track claim status and as a result employers/carriers are unable to request medical records or medical evaluations
- Work assignments do not account for experience, skill, or current workload resulting in personal backlogs and quality issues which delays processing
- Excessive handoffs back and forth across many groups adds to processing time (Neighbor Islands, Mail Clerk, Records & Claims, Research & Statistics, ICSD Key Punch) Note: During payroll ICSD's priority is to process payroll therefore claim keypunch is put on hold.
- There is an administrative requirement to file claims locally and in multiple copies (12-10-61, HAR). Neighbor Islands receive claim forms, review in paper copy and immediately send to Honolulu for entry, then forms are mailed back

### Annual Claims Report Processing and Claims Closure

- Carriers submit year-end reports and claim closure forms in multiple copies on pink paper
- Only three insurers submit electronically
- Year end figures are not always accurate to payouts

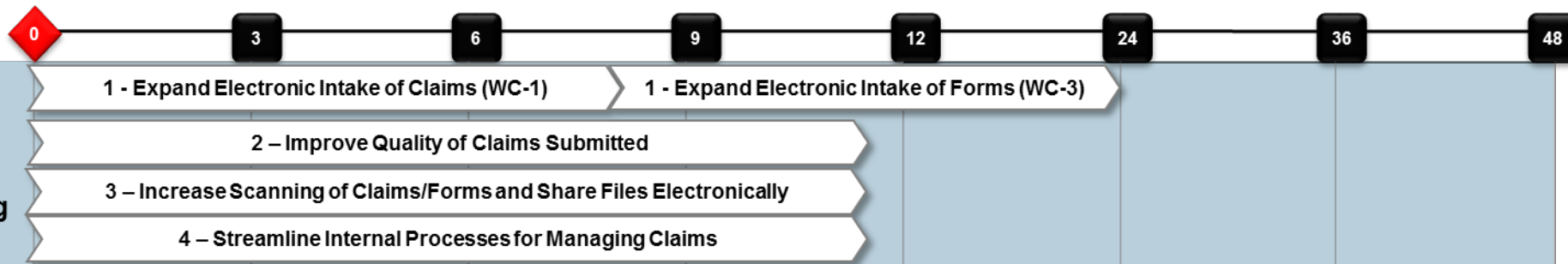
# Claims Processing and Tracking

## Process Improvement Plan

<b>Compliance</b> Policy Plans Development and Roll-Outs; Compliance Enforcement/Pursuit, Assessments and Collections, Audits, Investigations	<b>Customer Service</b> Client Outreach; Inquiry Handling; Documentation Services; Waiver, Agreement Scheduling
<b>Claims Processing and Tracking</b> Claims Intake, Annual Claims Report Processing, Claims Closure for Settlement/Reserve Administration/Recovery/Recovery	
Recovery Process/Intake and Review, Hearing/Dispute Management, Disability Evaluation, Deferred Processing, Hearings, Appeals Processing, Adjudication, Fee Assessments Collection/Disbursement, Case Management, Case Progression, Case Closure	
<b>Claims Adjusting</b> Eligibility Verification for Permanent Total Disability, Approval and Payment of Ongoing Treatment and Benefits (Other Paid by Third)	
<b>Vocational Rehabilitation</b> Conduct Assessment, Review Rehabilitation Plan, Review Vocational Rehabilitation Plan, Close Vocational Rehabilitation Case	

- 1. Expand Electronic Intake of Claims (WC-1) / Forms (WC-3)** – expand existing technology to provide capability to additional carriers
- 2. Improve Quality of Claims Submitted** – establish a quality control process to track quality of submissions and collect information needed to improve forms and educate carriers; establish a baseline and track improvement in data quality; request a statutory change from the legislature to require data quality in addition to timeliness
- 3. Increase Scanning of Claims/Forms and Share Files Electronically (rather than moving paper around)** – acquire needed technology (scanners, bar code scanners, SAN capacity, etc.) and implement processes (e.g., meta data indexing)
- 4. Streamline Internal Processes for Managing Claims** – evaluate feasibility of “fast track” for claims with denied compensability and implement a pilot; move Research & Statistics quality assurance step; use skills-based assignment and track performance; develop a training program

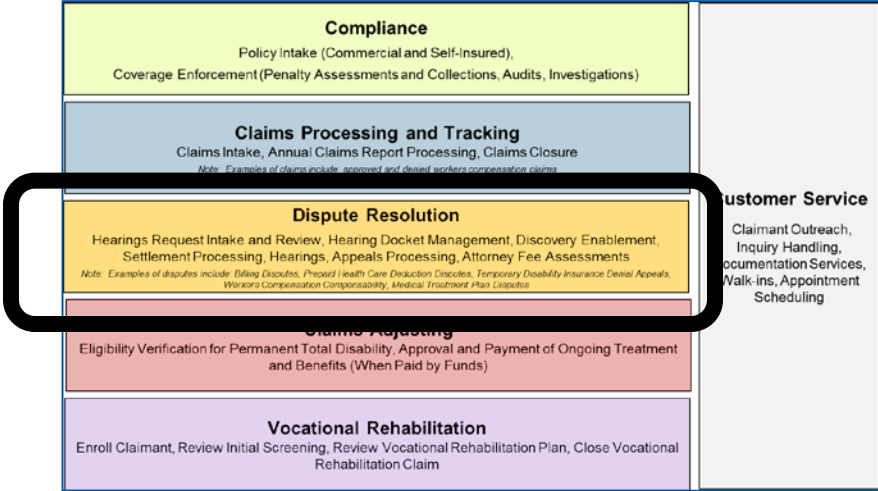
Timeline\*  
(months)





# Dispute Resolution

## Part 1: Business Process Optimization Analysis



# Dispute Resolution

## Key Process Issues



### Intake Hearing Request (WC-77 & WC-5)

- Forms include minimal submission instructions and submissions are often incomplete or inaccurate resulting in back and forth communication, email, letters and phone calls

### Billing Disputes

- Sizeable backlog (lower priority no statutory timeline for turnaround)
- Frivolous billing disputes (low dollar amounts) are sent to DCD for adjudication
- Decisions on Billing Disputes are sent to all stakeholders; claimant receives the decision and the claimant's attorney charges time to complete an unnecessary review of a document that doesn't pertain to the claimant

### Hearing Docket Management (Schedule resources, e.g., rooms, hearings officers, attorneys, etc., efficiently without double booking)

- Many cases are scheduled before all supporting documentation is provided (staff no longer completing WC Hearing File Review due to lack of resources). This leads to undocumented issues and to hearings exceeding the allotted time (25-30% of cases have incorrect or undocumented issues). Often results in a second hearing.
- Scheduling of hearings even though a WC-5 has not been filed resulting in “no decision” and wasting time
- Act 26 - need physician certification that claimant's condition will worsen if treatment is withheld - some hearings are expedited as ‘Medical’ without meeting criteria
- Addresses for outgoing mail often incorrect (10-20 returned letters a day)

# Dispute Resolution

## Key Process Issues (Continued)

<b>Compliance</b> Policy Waiver (Continental and Bell-Howell), Coverage Enforcement/Priority Assessments and Collections, Audits, Investigations	<b>Customer Service</b> Client Outreach, Injury Meeting, Documentation Services, Waiver Agreement Scheduling
<b>Claims Processing and Tracking</b> Claims/Make Annual Claims/Rapid Processing Claims/Disease	
<b>Dispute Resolution</b> Hearings Request/Make and Receive, Hearing, Conflict Management, Claimant's Enrollment, Self-Report/Processing Hearings, Hearings Processing, Attorney Fee Assessments	
<b>Claims Adjusting</b> Eligibility Verification for Permanent Total Disability, Approval and Payment of Ongoing Treatment and Benefits (Other Paid by Third)	
<b>Vocational Rehabilitation</b> Conduct Claimant, Receive Rehabilitation Screening, Review Vocational Rehabilitation Plan, Close Vocational Rehabilitation Case	

### Hearings/Adjudication/Documentation of Dispositions

- Junior Hearings Officers spend significant time mediating frivolous low dollar billing disputes which limits staff available for reviewing settlement agreements
- Limited tools for completing legal research e.g., Lexus Nexus – Lack of convenient searchable access reference material for all WC decisions potentially causing inconsistent dispositions
- Formal legal training was provided in the past but is no longer provided to Hearings Officers resulting in uneven quality. Training stopped due to staffing shortage and lack of funds
- The current process for quality assurance and review of decisions is resource intensive and highly ineffective
- Decision may be issued with or without a formal hearing, and may simply serve as a notification of a legal issue outside DCD jurisdiction (e.g., notification of child support lien – this is redundant since child support enforcement have already sent the notice and have jurisdiction)

### Disfigurement Evaluation/Hearing

- Not all claimants are aware of their right to disfigurement compensation, educational material is only provided by DCD when compensability was denied (when mailing out the WC-5). DCD used to get about 10 walk-in disfigurement evaluations/week, the number of claimants proactively reaching out has dwindled, it appears insurers are not adequately informing claimants of their rights for claiming disfigurement benefits
- Process of reaching out to insurers individually for waiver is time consuming; if the insurer fails to return the waiver request, a hearing must be scheduled. Sometimes make it through the process and the claimant notifies DCD that he/she does not have a disfigurement anyway



# Dispute Resolution

## Key Process Issues (Continued)



### Settlement Processing

- Settlement & Stipulation Agreement review process is slow and error prone
- Administrative rules require all settlement changes to be initialed/agreed upon by parties, no matter how minor. Approximately 50% of settlements require fixes
- It's not uncommon for Stipulations to be mailed back and forth between attorneys multiple times before all errors are corrected

### Review of Attorney Fees

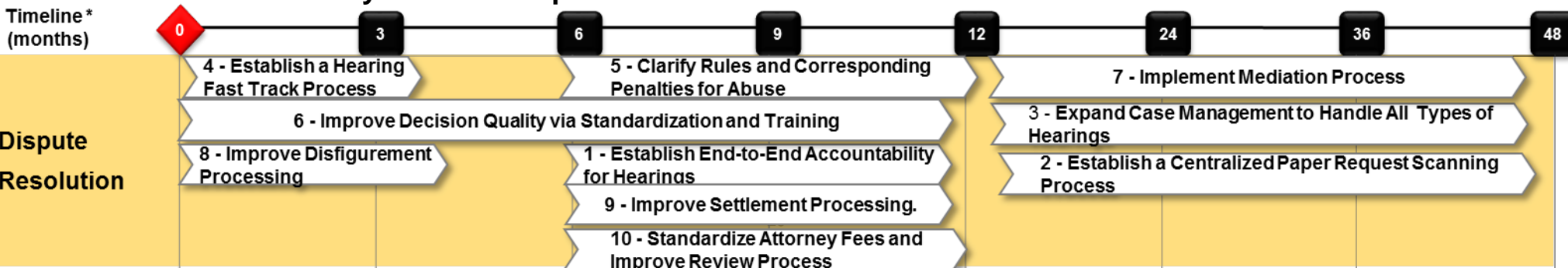
- HO's were directed to assess attorney fees as "reasonable" up to 20% of the award (if greater than 20% HO's were directed to scrutinize closely all fees and make a determination whether to write down fees). As soon as this change went into effect, attorneys immediately began submitting fees at about around the 20% mark
- A prior DLIR DCD Administrator changed procedure to allow attorneys to submit fees intermittently after hearings rather than after PPD has been decided, HO's stopped assessing reasonableness of the full amount and no longer check for a percentage cap against the ultimate award (though historical information is available within Lotus Notes but would require opening each prior decision document to get to attached attorney fee documents and doing a manual calculation across each of these documents) and it's also difficult for HO's to assess whether attorney fees are submitted in a timely fashion
- Reviewing attorney fees is a time consuming manual process that often involves adding up pages of line items of expenses
- Attorneys sometimes complete frivolous activities and submit attorney fees for these activities (e.g., appealing a decision that was mutually agreed and then withdrawing the appeal)

# Dispute Resolution

## Process Improvement Plan



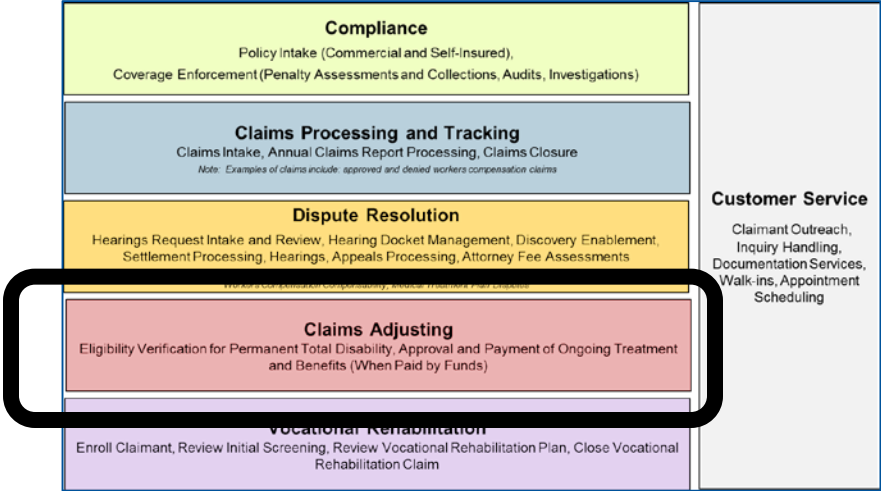
1. **Establish End-to-End Accountability for Hearings** – give Hearings Branch end-to-end control of hearings by realigning upfront screening and scheduling, and realigning quality accountability; introduce training for Hearings Officers; begin tracking elapsed time from scheduling to completion with annotations for causes of delays
2. **Establish a Centralized Paper Request Scanning Process**
3. **Expand Case Management to Handle All Types of Hearings**
4. **Establish a Hearing Fast Track Process** – prioritize medical cases, denied compensability, and employer delinquencies for hearing fastrack that includes pre-hearing meeting
5. **Clarify Rules and Corresponding Penalties for Abuse** – track attorneys who repeatedly misuse the systems; work with legislature to introduce a “failure to appear” penalty; clarify and enforce guidelines for “Good Cause” extensions; work with legislature to establish policies to minimize frivolous lawsuits
6. **Improve Decision Quality via Standardization and Training**
7. **Implement Settlement Process** – establish a pilot to provide greater support to parties interested in settling and track outcomes, expand if feasible
8. **Improve Disfigurement Processing** – educate the claimants on their rights (e.g., add info to WC-3) and work with carriers to re-institute blanket waivers to enable walk-ins
9. **Improve Settlement Processing**
10. **Standardize Attorney Fees and Improve Review Process**





# Claims Adjusting

## Part 1: Business Process Optimization Analysis



# Claims Adjusting

## Key Process Issues



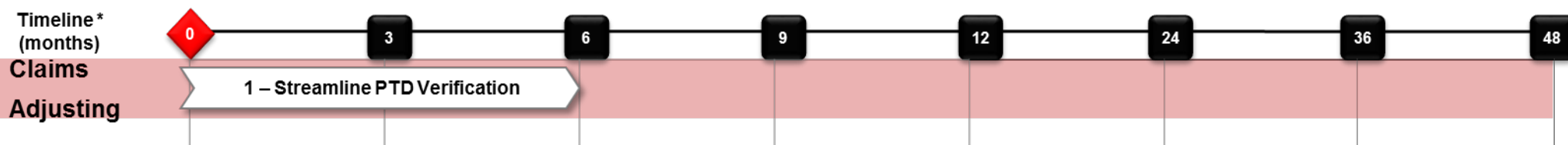
### Verify Eligibility for Continued Permanent Total Disability (PTD)

- Investigations only gets involved in ongoing PTD cases for annual eligibility review and is therefore out of the loop and unaware of the current status of PTD payees. Investigations Supervisor must track down details on why a payee has stopped receiving payments (verify accuracy of the list for PTD verification prior to sending out letters).
- The work is more clerical in nature (only very few field investigations follow ups are required <5%) rather than investigative. (Process evolved from face-to-face confirmations to mailing out DC-300.)
- PTD recipients are confused by the number of people involved in their case and are unclear who within DCD to contact (there are three points of contact: Admin, Facilitators, and Investigators). The Investigations Supervisor's phone number is listed on the annual PTD verification letter so claimants frequently call the supervisor directly for other unrelated items.

# Claims Adjusting Process Improvement Plan

<b>Compliance</b> Policy Rate Commercial and Self-Insured, Coverage Enforcement/Priority Assessments and Collections, Audits, Investigations	<b>Customer Service</b> Client Outreach, Injury Meeting, Documentation Services, Walk-in Appointment Scheduling
<b>Claims Processing and Tracking</b> Claims Intake, Annual Claims Report Processing, Claims Closure for Non-Insurance Administrative Requirements	
<b>Dispute Resolution</b> Hearings, Request Intake and Review, Hearings, Dispute Management, Claimant's Enrollment, Settlement Processing, Hearings, Appeals Processing, Adjudication Assessments	
<b>Claims Adjusting</b> Eligibility Verification for Permanent Total Disability, Approval and Payment of Ongoing Treatment and Benefits (When Policy Permits)	
<b>Vocational Rehabilitation</b> Conduct Assessment, Review Initial Screening, Review Vocational Rehabilitation Plan, Create Vocational Rehabilitation Case	

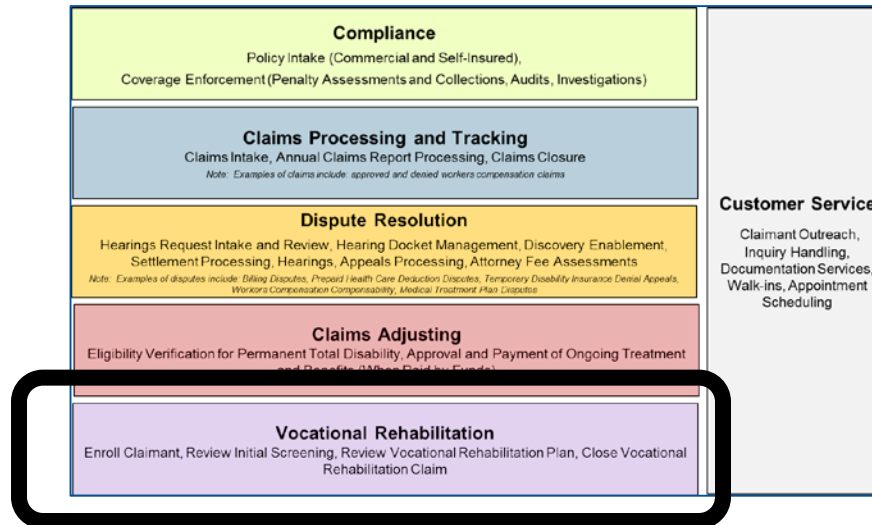
- 1. Streamline Ongoing Permanent Total Disability (PTD) Eligibility Verification** – streamline organizational responsibility for handling PTD cases paid out of the WC Special Compensation fund by expanding Facilitator role to align with original intent so they are involved in supporting claimants through the process from end-to-end





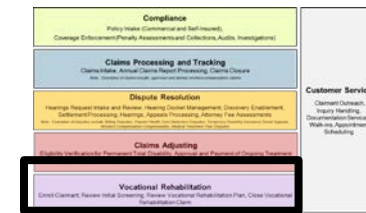
# Vocational Rehabilitation

## Part 1: Business Process Optimization Analysis



# Vocational Rehabilitation

## Key Process Issues



### Enroll Claimant, HRS 386-25(b)

- Currently with only one DCD staff person assigned, referrals are not being made. Historically the insurance carriers would refer out employees

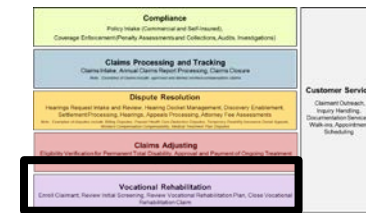
### Review Initial Screening, Review VR Plans, and Close VR Claims (HRS 386-25, HAR Title 12, Chapter 14)

- There is no tracking of actual claimant outcomes (placements or longitudinal success metrics) only anecdotal stories of failure that indicate a systemic issue with the way DCD oversees VR
- There is no tracking of outcome by counselor and no way to assess counselor performance rendering DCD's certification authority as relatively meaningless
- Only one person is assigned to Vocational Rehabilitation and there is no backup. HAR 12 -14-10 requires the director to act upon a plan within 21 calendar days or it is accepted or denied by default. If the staff member goes on vacation there is no one to process or review documentation submitted and it creates a backlog, and there is no one available to provide responses to inquiries on VR
- While DCD is reviewing VR Plans for alignment to the letter of the law, many plans are not in the best interest of the claimant (e.g., claimant plan is to become self-employed with no prior experience of self-employment) and often leaves the claimant under employed or receiving a much lower compensation than prior to the injury
- Also, many plans are not a reasonable expense to the Employer (e.g., a plan may ask the Employer to fund a new start up business or fund education for a Master's degree when a Bachelor's degree is appropriate)

### Review Initial Screening, Review VR Plans, and Close VR Claims (Continued)

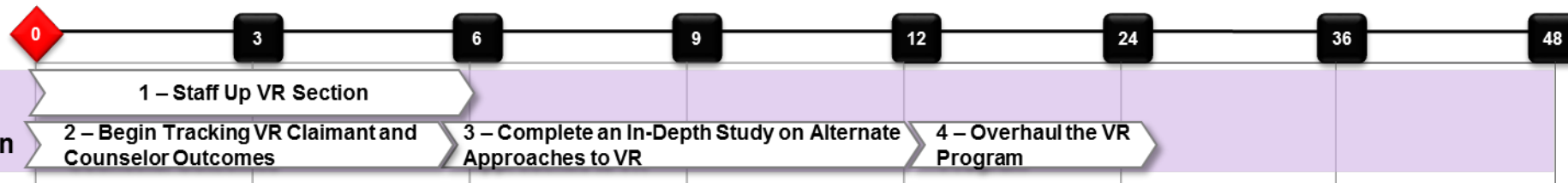
- Forms include minimal submission instructions and submissions are often incomplete or inaccurate
- No electronic submission of forms
- HAR 12-14-30(d) requires Objections of closing reports to be clearly identified in capital letters in no less than ten point type, an unnecessary rule

# Vocational Rehabilitation Process Improvement Plan



1. **Staff Up VR Section** – identify volunteers and cross-train backups; request additional positions from the legislature
2. **Begin Tracking VR Claimant and Counselor Outcomes** – identify metrics (e.g., average time to placement by severity of disability, average time to placement by counselor, claimant income as percentage of pre-disability income, etc.), design a multi-year follow-up survey to assess outcomes
3. **Complete an In-Depth Study on Alternate Approaches to VR** – conduct an in depth alternative analysis leveraging the data completed in step 2 (above) to compare the status quo to any proposed program changes
4. **Overhaul the VR Program** – leverage the results of the in-depth assessments to propose improvements to the VR Program, work the proposed changes through stakeholder groups (unions, claimant representatives, counselors, employers, insurers, etc.), and put together a bill to update the statute

Timeline\*  
(months)







## Part II: Technology Modernization

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# Technology Modernization

## Key Challenges

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**The business process optimization initiatives discussed in the previous section will incrementally improve DCD. However, for DCD to transform into a modern, efficient, customer-focused, service-delivery organization, there are several technology challenges which need to be overcome:**

- **Multiple, Non-Integrated Applications:** Related activities across the multiple systems cannot be concisely tracked and reported on; business decisions are adversely affected by the inability to readily obtain timely and accurate information when needed. Additionally, data in common among the systems must be entered directly into each system
- **Outdated Technology:** DCD's primary application (the DCIS system) is a 20+ year old COBOL mainframe application which cannot readily support legislative changes or capabilities such as integrated document management and fraud analytics
  - As a result, the availability of programming skills needed to maintain and enhance DCIS is significantly limited, leading to increased risk of system failure
  - Also, the structure of COBOL programs make them inherently complicated and difficult to change in a timely manner. As a result, many necessary modifications to the system have not been completed
  - DCD currently utilizes two systems that perform case management-like functions. These systems consist of home grown Lotus Notes databases used for tracking of workflow, as well as a DCIS mainframe system that also tracks workflow and includes some unemployment insurance and disability compensation tables and data. These systems currently do not fully track the full claims processing lifecycle, require some manual entry, and require redundant entry between both systems

# Technology Modernization

## Key Challenges

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- **Paper-Based Processes:** DCD business processes rely heavily on paper resulting in:
  - Delayed claims and appeals adjudication as staff must track down paper forms that can sometimes take weeks to locate
  - Reduced staff efficiency due to multiple hand offs of paper and time spent searching for information scattered throughout the Department
  - Difficulty monitoring operations, productivity, and identifying bottlenecks leading to reduced quality of outcomes as DCD staff must often make decisions based on incomplete information
  - Poor customer service as citizens have to wait weeks to get answers back on simple questions. Difficult, if not impossible, to offer self service functionality being demanded by citizens
  - Increased storage costs associated with keeping paper records
  - Inability to recover in the event of a disaster (fire or flood)
  - Increased risk of security and privacy breaches with personal information spread throughout the Department

## Technology Modernization

### Recommendations (Plan)

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**The team is proposing 3 major initiatives to further streamline and automate DLIR process to improve, efficiency, quality and timeliness, and to improve customer service. These initiatives are independent and DCD can elect to implement any combination of the three.**

- **Electronic Data Interchange (EDI) Intake (i.e., electronic claims intake)**
  - Provide a more efficient capability for the electronic intake of claims using an Electronic Data Interchange (EDI) clearinghouse service that can accommodate 100% of claims filings
  - Leverage EDI rather than paper or an encrypted text file, to receive claims in bulk and get upfront data validation of claims upon submission, to avoid manual data correction and follow up activities
  - Consider taking the additional step of mandating EDI claim submission via statute
- **Business Process Automation and Case Management (i.e., business process workflow)**
  - Implement a Business Process Management Suite (BPMS) that will transform claims processing into a paperless process, leveraging automated workflows and configurable assignments, provide advanced reporting and analytics capabilities
  - These changes will shorten the claims processing cycle, improve claims adjudication, improve stakeholder communication, improve management reporting, increases staff productivity, and reduces costs.
  - Also automate investigations business process workflows and implement rules-based, transparent investigation assignments
- **Self Service Portal (online services for claimants as well providers)**
  - Implement an online portal for online document and form submission and tracking