Appendix A

State Health Agencies' Access to State Workers' Compensation Data: Results of an Assessment Conducted by the Council of State and Territorial Epidemiologists, 2012

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Purpose

The Council of State and Territorial Epidemiologists (CSTE) has a cooperative agreement with the National Institute for Occupational Safety and Health (NIOSH) to help states build capacity to conduct surveillance of work-related illnesses and injuries. One potentially useful source of occupational health surveillance information is Workers' Compensation (WC) claim data[1]. To learn more about whether state public health departments have access to WC data for surveillance purposes and the type of data they have access to, CSTE conducted a brief assessment of health departments in the states. The assessment findings will help CSTE plan future efforts to increase state capacity to use WC claim data for surveillance of work-related injuries and illnesses.

Methods

In March, 2012, a workgroup comprised of representatives from CSTE with input from OSHA developed the CSTE Assessment of State Public Health Department Access to State Workers' Compensation Data. A pilot questionnaire was administered to three states and edited as indicated. The final assessment included 27 individual questions regarding data access, the type of data accessed, the format of the dataset, use of the data, and any barriers or restrictions placed on state WC claims data available to the public health department.

The assessment was made available to all 50 states and the District of Columbia via a Web-based application on April 20, 2012 and remained open for completion for one month. The occupational health contact[2] in each jurisdiction served as the primary informant, although, where applicable, contacts were asked to refer the questionnaire to the person within their department most appropriate for completing the assessment. Thirty-eight jurisdictions completed the assessment. Follow-up was conducted in August 2012 with three jurisdictions to resolve inconsistencies. In this document, 'states' and 'respondent' refers to all 50 states as well as the District of Columbia.

Results

Thirty-eight (75%) state health departments responded to the assessment. Percentages reported below are calculated using the 38 responding states as the denominator.

Access to electronic WC claim data

Eighteen state health departments (47% of respondents) indicated that they had access to an electronic database of WC claim data maintained by the state WC agency[3]. Of the 20 (53%) respondents that did not have access to an electronic database of WC claim data[4]:

- Seven states reported that they had not tried to access the data.
- Three states reported that the WC agency did not maintain electronic records, but they have access to paper records.
- Seven states reported that legal and confidentiality issues were barriers to accessing workers' compensation claim data.
- Two states reported that other agencies maintain data and will provide information upon request;
- One state cited general data access issues as a barrier; and

- One state reported that another agency maintains the data and prefers to work on its own.

Type of WC data accessed

- Five (13%) state health departments reported having access to information about lost wage claims only.
- Twelve (32%) states reported having access to information about both lost wage and medical claim data[5].
- One (3%) state did not know the types of claim data to which they had access.

Types of records accessed

- Thirteen (34%) state health departments reported having access to Employer First Reports of Injury. Among these, four states reported also having access to Physician First Reports.
- Five (13%) states did not know specifically from which records the information received is obtained.

Claims filed vs. claims awarded

- Nine (24%) state health departments reported that they could differentiate between claims filed and claims awarded.
- Six (16%) states reported that they had information on all claims filed but did not have information on whether claims were awarded, pending or denied.
- Three (8%) states reported having data on awarded claims only.

Timeframe

- Two (5%) states reported having daily online access.
- Two (5%) states have weekly access.
- Two (5%) states have monthly access.
- One (3%) state has quarterly access.
- Three (8%) states have annual access.
- Eight (21%) states have access on request only.

One state with weekly and the one with quarterly access have access to claims only for targeted health conditions in these time frames but access to all claims annually. These states were categorized at the most timely point of access.

Several states with routinely scheduled access also reported being able to obtain additional data on request. One state noted that although they receive real time access to self-insured claims, these are not entered into the electronic database.

Data format

- Two (5%) states had online web-based access.
- Eight (21%) states received data through electronic transmission of files to the agency.
- Five (13%) states reported that the data are sent to the public health agency on CD ROM.
- One (3%) state reported access only to paper reports of computer generated files.
- One (3%) state reported actively download data from state mainframe and one (3%) state received the data through a state data clearing house.

Some states reported receiving data in multiple modes. In those instances, these states are categorized by the fastest mode. For example if a state received data both by CD ROM and electronic transmission, this state is included in the electronic transmission category.

- Fourteen (37%) states reported that data can be readily searched and analyzed.
- Four (11%) states reported that while some data can be readily searched and analyzed, other data is in scanned format only.
- No state reported access to data in scanned format only.

Restrictions on data access

- One (3%) state reported having access to claim data only for conditions reportable to public health.
- Seventeen (45%) states reported access to claims for all health conditions. As noted above, in several states, the timeframe for accessing data on targeted conditions was more frequent. One state reported getting personal identifiers for reportable conditions only.

Interagency memoranda of understanding

- Among the 18 state health agencies accessing WC data, 12 have memoranda of understanding with the WC agency, and 6 do not have memoranda of understanding.

Restrictions on data use

- Ten states can use the WC data for aggregate data analysis only. Three of these states reported specifically that they may not use the data for public health follow-up of workers or worksites or for referral to enforcement agencies. One of these reported that they receive neither worker nor employer identifiers.
- Of the remaining eight states, two reported having no restrictions "other than HIPPA requirements" or "as long as appropriate authorities are contacted" and five reported not being able to release the name of the worker either publically or to other agencies; three reported not being able to release the name of the employer publically and two of these could not release the name of the employer to other agencies.

WC agency review of reports

- Four (11%) states reported that they may only publish summary data after review and approval by the WC agency.

Information on dollar amounts awarded to workers

- Six (16%) states have access to information on the dollar amount awarded.
- Ten (26%) states have no information about the dollars awarded.
- Two (11%) states with access to WC data didn't answer the question.

How state public health agencies are using WC data[6]

- Eleven (29%) states use data for Occupational Health Indicators.
- Five (13%) states use data for individual case follow-up.
- Nine (24%) states use data for routine summary data analysis.
- Ten (26%) states use data for periodic special studies of select populations or health conditions.
- Eight (21%) use data in multisource surveillance of targeted conditions
- One state reported using as a source of information for their Bureau of Labor Statistics – Census of Fatal Occupational Injuries program.

Barriers to using WC data for occupational health surveillance

The most highly ranked barrier to using WC data was limited resources, followed closely by "missing key data elements." Data quality issues, and lack of understanding of the data were also relatively highly ranked barriers.

Suggestions for improving use of WC data by state public health agencies

- Seven states (18%) requested assistance in engaging the WC agencies in order to access or maximize use of the WC data. All but one of these seven states were states without access to electronic WC data. Several emphasized the importance of demonstrating a business case and rational for using the data from a public health perspective. "Describing success stories in other states that were able to access and use the data would be useful. "We also must explain the benefit the WC agency would get from sharing the data." Two of the states without access suggested actively educating WC agencies about use of the data for prevention purposes, for example, including WC agencies as well as public health contacts in a webinar on use of the data for prevention.
- Four states (11%), all of which had access to the WC data, reported that additional training on methods and examples of how to analyze and use WC data would be beneficial to their health agency. One state suggested that one-on-one technical assistance would be useful. "We need help in looking at the data and figuring out how to use it."

Table 1. Data elements to which state public health agencies have access in WC data sets

Data element	States with access N	Percent of respondents %
Worker identifiers		
Worker name	10	26
Worker address	9	24
Worker phone number	6	16
Date of birth	16	42
Race/ethnicity	4	11
Preferred spoken language	1	3
Occupation text	10	26
Occupation code	7	18
Bureau of Census (BC)	2	5
Standard Occupational Classification (SOC)	5	13
Both BC and SOC	1	3
Other - unique to WC system	1	3
Employer identifiers		
Employer name	13	34
Employer address	11	29
Employer phone	10	26
Incident location if different than employer address	7	18
Industry description	5	13
Industry code:	14	37
North American Industry Classification System (NAICS)	10	26
Standard Industrial Classification (SIC)	11	29
Both SIC and NAICS	7	18
Injury/illness descriptors		
Nature of injury/illness narrative	7	18
Nature of injury/illness code		
Occupational Injury and Illnesses Classification (OIIC)	6	16
International Association of Industrial Accident Boards and Commissions (IAIABC)	5	13
International Classification of Disease (ICD)	5	13
Workers' Compensation Insurance Organizations (WCIO)	3	8
Other	4	11
Body part descriptors		
Body part narrative	6	16
Body part code:		
OIIC	6	16
IAIABC	0	0
ICD	2	5
Other	5	13
Incident descriptors		
Narrative description of incident	7	18
Date of incident	15	39
Location of incident if different than employer address	8	21
Source narrative	5	13
Source code:		
OIIC	5	13
Other	3	8

- Two states suggested help with standardized coding of the variables, one of which asked for NIOSH coding of industry and occupation. One state suggested seed funding would be helpful for converting their existing system into a fully electronic system, and one additional state would like CSTE to assist them by providing legal guidance on how to overcome confidentiality barriers in WC statutes.

Discussion

Close to half of the responding state public health agencies have access to electronic WC data. This is a significant advance in occupational health surveillance in the states as WC data can be a valuable resource providing critical information for targeting state efforts to prevent work-related injuries and illnesses. State health departments can bring to bear their epidemiologic knowledge and skills to maximize use of this administrative data for surveillance and ultimately prevention purposes.

Notably WC claim data can add substantially to state specific information available from the Survey of Occupational Injuries and Illnesses (SOII). SOII, at the state level, is limited by its relatively small sample size and often cannot provide detailed information by injury or industry characteristics. Also, in contrast to WC data, SOII data currently cannot be aggregated over years.

While assessment findings indicate that state public health agencies can use WC data for population-based surveillance and targeting, restrictions on data use appear to limit its utility for case-based surveillance and case follow-up with either workers or specific employers in many states. Ten of the 18 respondents with access to WC data can use the data for summary data analysis only; two additional states have restrictions on releasing names of employers to other agencies. Thus while the public health agencies in these two states may potentially conduct case or worksite follow-up, they cannot refer cases to enforcement agencies. This leaves only 6 public health agencies that can refer cases for enforcement. However, some state labor departments may have access to WC data for enforcement purposes. This remains to be investigated.

Another notable finding is that a number of state public health agencies do not appear to have sufficient information about the nature, quality and characteristics of the data to which they have access. WC systems are complicated systems, and they vary markedly by state. It is important for epidemiologists using the data to work with the WC agency staff to develop a better understanding of the WC systems in their states and of the data to which they have access. CSTE should provide opportunities for states with more experience using WC data to teach other states about data issues and approaches to maximizing usefulness of WC data for prevention. CSTE should also work with states in developing materials or programs to engage their WC agencies by demonstrating the value of using the WC data for prevention.

Finally it should be noted that there is substantial variation in the types of WC data to which the state public health agencies have access, for example, all claims versus lost time only, awarded claims versus claims filed. These differences in what data can be accessed in different states plus known eligibility differences for WC in different states limits comparison of these data across states. No comparison of data between states should be made without first taking into account what effects differences in access and eligibility have on the data being compared.

Limitations

There are several limitations to this assessment which should be taken into account. First, 13 states, representing 11.5%[7] of the working population in the country, did not complete the survey. If none of the 13 non-responding states had access to WC data, then the percentage of health departments with access would be 35%. If all 13 states had access, then the percentage would be 61%. We suspect that the non-responding states are less likely either to

have access or, if they have the legal right to the data, to actually access their state's WC data and the true percentage with access to WC data is closer to 35%. Secondly, only 23 states are funded by NIOSH to conduct occupational injury and illness surveillance that includes use of WC data. The assessment was sent to the individual responsible for the surveillance program in each of these states. In the other 28 states, it is possible the assessment did not reach the person in the state health department knowledgeable about WC data, and therefore the responses from these 28 states may not be accurate.

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[1]Note that state WC systems do not provide information about injuries and illnesses among workers' covered under other WC systems including federal workers covered under the Federal Employees Compensation Act (FECA), workers covered under the Longshore and Harbor Workers Compensation Act (LHWCA), workers covered by the Black Lung Benefit Program, former nuclear weapons workers covered under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), and interstate railroad workers covered under the Federal Employers Liability Act (FELA).

[2]CSTE, in collaboration with NIOSH, maintains an updated list of occupational health contacts in state public health agencies. This list is available at: www.cste.org. Washington State is an exception in which the lead contact for occupational health surveillance is in the Department of Labor and Industries.

[3]One additional state health department indicated that it had access to WC claims only for workers in the health department.

[4]States could select multiple answers to this question. Among the 20 states without access to electronic WC data, there were 21 responses from 18 states. Two of the 20 states did not respond to this question.

[5]These 12 included one state that reported "medical claims only" and another that reported access to "First Reports of Injury only" i.e. if state reported access to First Reports of Injury or medical claims only and no additional information was provided, it was assumed that they have access to information about all claims not just those resulting in lost time.

[6]States could select multiple answers to this question.

[7]Obtained from: 1) Bureau of Labor Statistics. Geographic Profile of Employment and Unemployment, 2011. Available at: http://www.bls.gov/opub/gp/pdf/gp11full.pdf (Accessed November 16, 2012). 2) Bureau of Labor Statistics. Employment status of the civilian noninstitutional population, 1941 to date. Available at: http://www.bls.gov/cps/cpsaat01.pdf (Accessed November 16, 2012).

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