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Retrospective Rating: What You Need to Know to Be Successful in the WSDA Retro Program

Julie Osterberg, ERNwest Retro Group Manager

Brent Olson, ERNwest Loss Control Manager

Objectives of today's session:

1. Understand the basics of Retro
2. Learn about the resources available to WSDA Retro members
3. Understand the most impactful injuries and prevention
4. Learn the importance of incident reporting
5. Understand the strategies to return your employees back to work and control costs

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What is Retrospective Rating?

- Washington is one of very few states with a “state-run” workers’ compensation program
- Labor and Industries is the provider for workers’ compensation in Washington
- The Retrospective Rating or “Retro” program has been offered for over 30 years by L&I
- Companies enrolled in Retro have an opportunity to earn a refund of some of the premium they pay to L&I

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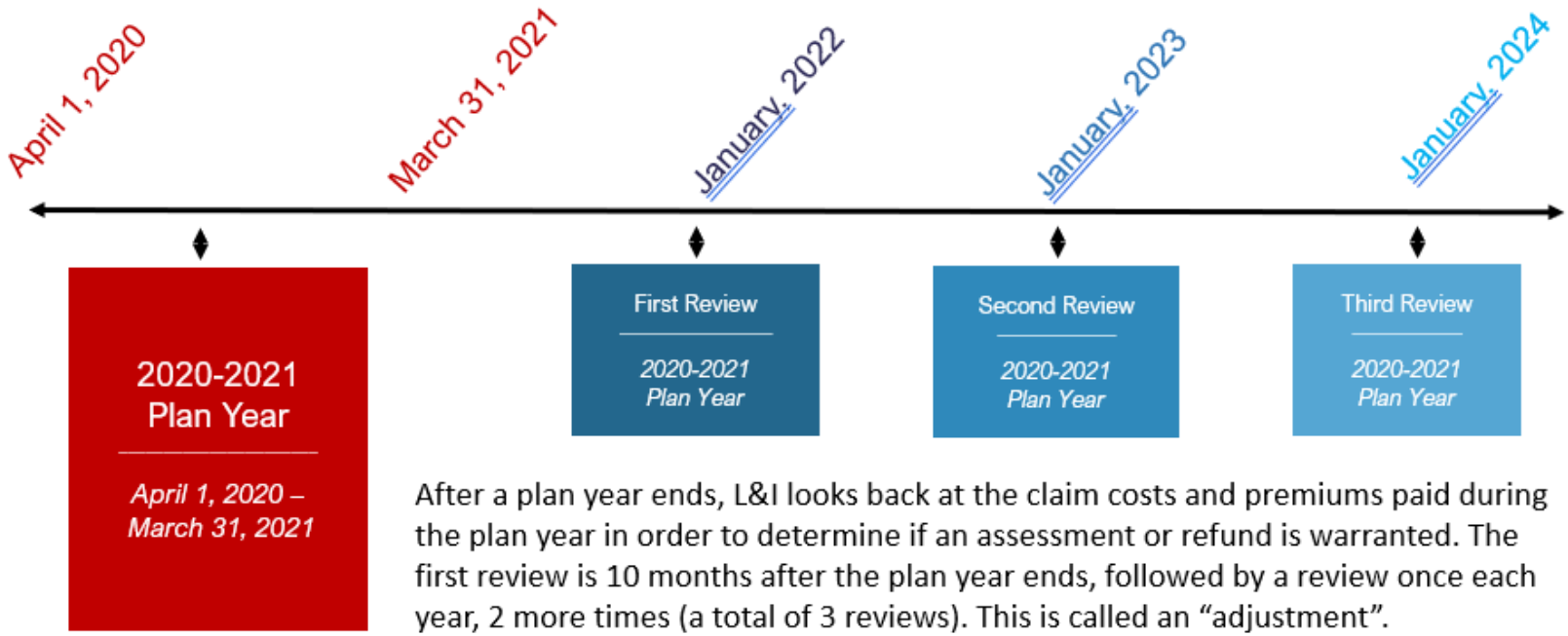
How Can You Earn a Refund?

Workers' compensation premium paid to LNI by WSDA Retro members.

Includes: workplace injury expenses (claims), future claim costs (reserves), L&I administration costs,

If this number is positive it is a refund and if it is negative it is an assessment (that WSDA will pay)

Retro Plan Year and Timing of Refunds



After a plan year ends, L&I looks back at the claim costs and premiums paid during the plan year in order to determine if an assessment or refund is warranted. The first review is 10 months after the plan year ends, followed by a review once each year, 2 more times (a total of 3 reviews). This is called an "adjustment".

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WSDA Retrospective Rating

<u>WSDA began sponsoring a Retro group in April 2020</u>

- WSDA partnered with ERNwest to assist in administering the program and helping its members when they have a claim
- Providing opportunity for refund for members

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Group Manager – assistance navigating L&I account issues, providing future premium rate estimates, assist with claim strategy and cost benefit, and coordinate services with other ERNwest staff

Claims Manager – review all reported incidents, monitor and manage your claims, identify cost saving strategies, assist with return to work and advocate with L&I on your behalf

Loss Control Manager – assist with Accident Prevention Programs, sample safety policies, Incident reporting and monthly safety webinars and industry specific safety tips

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Member Roles & Responsibilities

1. Your leadership in your practice is key in **prevention** and **control** of work-related injuries
2. Select an employee in your practice that is responsible for your worker's comp program and interaction with ERNwest
3. Whenever possible, keep injured employees working modified duty, within their restrictions
4. Implement the following:
    - Accident Prevention Program
    - Safety Training to all employees
    - Participate in Ongoing Training
    - Incident Reporting System

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You can address 98% of your workers' compensation program with three things:

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Safety & Incident Reporting

Objectives

- **Why is Safety Important**
- **Most Frequent Injuries in the Dental Industry**
- **Most Costly Injuries in the Dental Industry**
- **Injury Prevention**
- **Steps to Take After an Injury or Incident Occurs**

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Why Safety?

Why is safety so important?

Because we all deserve to return home safe and "whole" at the end of each workday

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Why Safety – True Cost

What are the costs associated with safety?

To Worker:

- **Pain**
- **Lost wages**
- **Temporary or permanent disability**
- **Reduced quality of life**
- **Depression**

To Employer:

- **Loss in productivity and business**
- **Increased industrial insurance premiums**
- **Increased liability insurance**
- **Training replacement worker**

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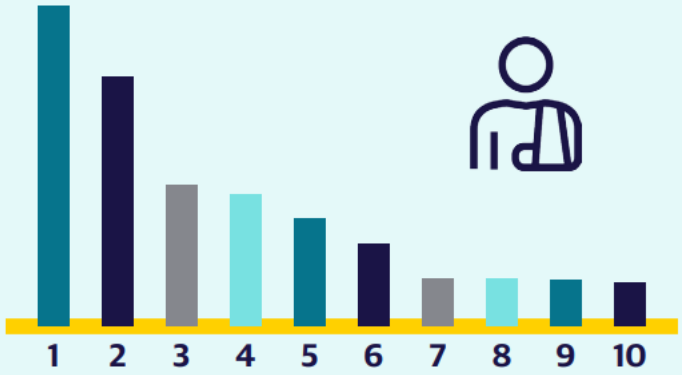
Why Safety – Top 10

Total cost of the most disabling workplace injuries: **$58.61 billion**

Cost of top 10 most disabling workplace injuries: **$52.28 billion**



	Cost billions	Percent total	
1.	$13.30	22.7%	**Overexertion involving outside sources** (handling object)
2.	$10.58	18.1%	**Falls on same level**
3.	$6.26	10.7%	**Falls to lower level**
4.	$5.61	9.6%	**Struck by object or equipment** (being hit by objects)
5.	$4.71	8.0%	**Other exertions or bodily reactions** (awkward postures)
6.	$3.16	5.4%	**Roadway incidents involving motorized land vehicle** (vehicle crashes)
7.	$2.52	4.3%	**Slip or trip without fall**
8.	$2.46	4.2%	**Struck against object or equipment** (colliding with objects)
9.	$2.01	3.4%	**Caught in or compressed by equipment or objects** (running equipment or machines)
10.	$1.66	2.8%	**Repetitive motions involving microtasks**

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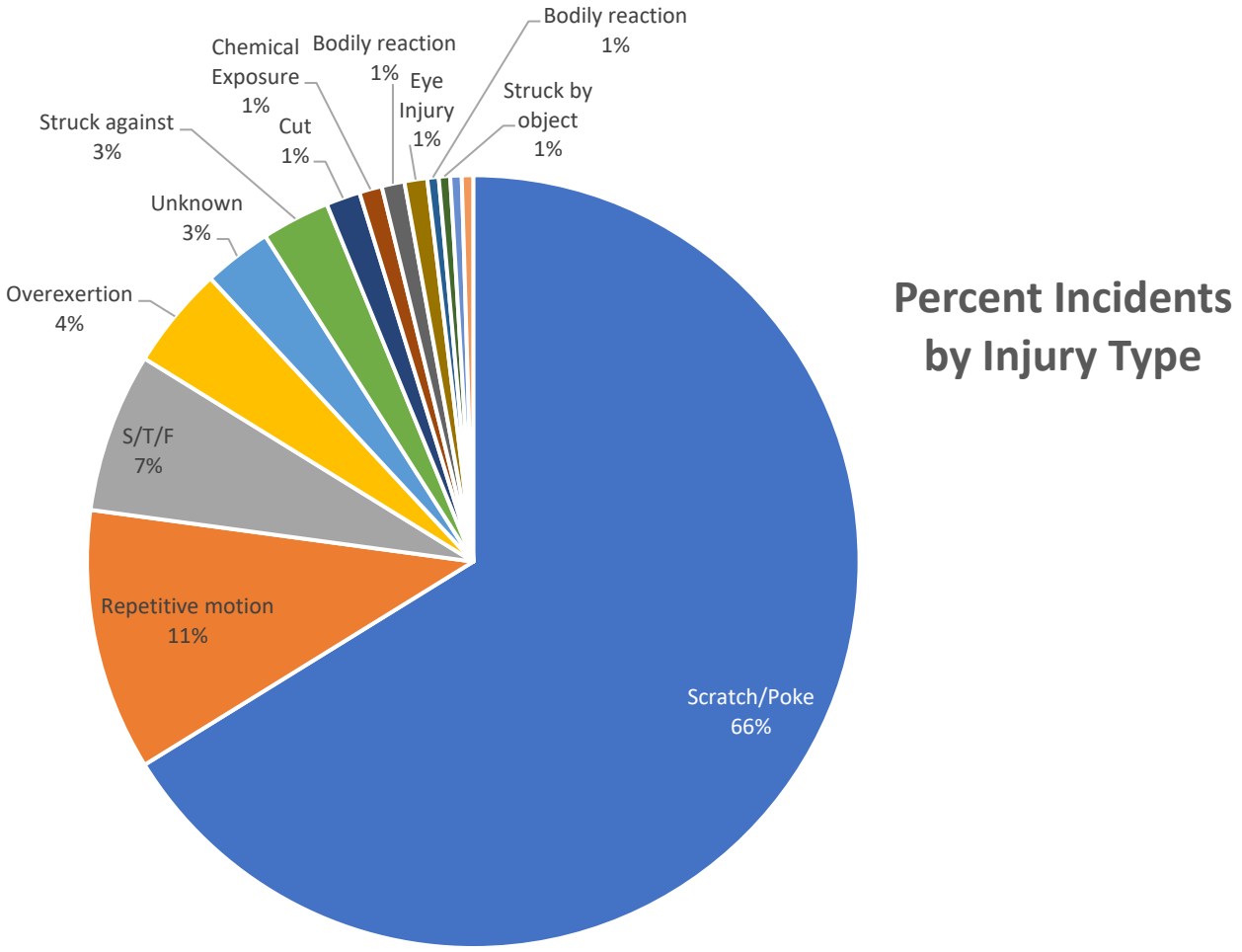
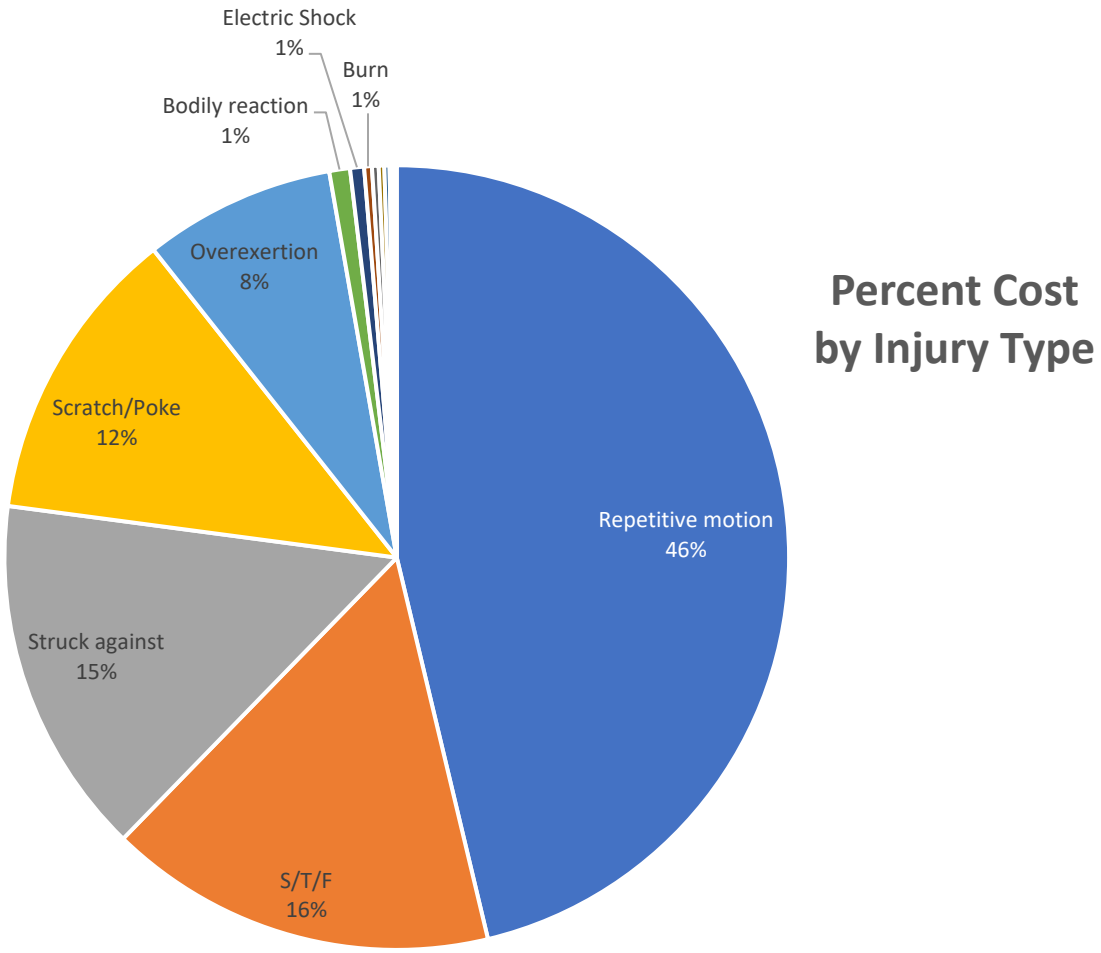
Frequency & Severity



Frequency & Severity



Frequency & Severity

Most frequent injuries are related to:

- Scratch/poke injuries from tools and needles (66%)
- Repetitive motion injuries (11%)
- Slip/Trip/Fall injuries (7%)

Most costly injuries are related to:

- Repetitive Motion – Carpel Tunnel Syndrome (46%)
- Slip/Trip/Fall injuries (16%)
- Struck against injuries (15%)

What Should We Focus On?

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Injury Prevention

Repetitive Motion – Carpel Tunnel Syndrome

- Try not to bend wrists at extreme angles while working
- Adjust patient's positioning, keep wrists in a neutral position
- Forceful pinching, as used during scaling, increases risk
- Try to use instruments that are lightweight and larger in diameter
- Use a different technique periodically
- Regular exercises can reduce risk of developing carpal tunnel
  - Make a tight fist with one hand, then release and spread out your fingers. Repeat this five times for each hand.
  - Pull your thumb back and away from your palm for five seconds. Repeat this five to 10 times for each hand.
  - Keep your pointer and middle fingers extended, while the rest are down (like a peace sign). Then draw five clockwise circles with your raised fingers, then repeat in a counterclockwise motion. Repeat for the opposite hand.

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Injury Prevention

Slip, Trip, Fall Injuries

- Non-slip shoes (not all tennis shoes are non-slip)
- Cleanup spills/water immediately & use wet floor signs
- Remove clutter from walkways (deliveries, stored boxes, garbage cans, cords)
- Slow down

Scratches & Pokes

- Use safety cap needles
- Puncture resistant gloves for certain activities
- Slooooooow down

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What to do if someone gets hurt?

We will discuss:

- Incident reporting
- Seeking medical attention
- Employer, Supervisor, Employee involvement
- Level of post accident investigation

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Incident Reporting - Why Care?

The value of incident reporting is huge:

- Reduces claim cost – claims reported within a week are 44% less expensive than those reported at four weeks.
- Attorney involvement – 16% increase in attorney involvement if reported after 4 weeks.
- Claims close faster – only 29% of claims filed after four weeks are closed at 18 months.
- Assists safety in identifying how incidents occurred.
- With proper communication, demonstrates caring and accountability.
- Provides claims managers with critical information.
- Assists with fraud prevention.
- With relatively minor injuries, this can be done prior to medical treatment, otherwise complete it as soon as medical treatment has been provided.

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Who should be involved?

- Employee's direct supervisor
- Employee
- Any witnesses

Pre-Incident Best Practices

1. Conduct annual training for employees
2. Establish and monitor reporting goals
3. Commit to modified return-to-work programs
4. Set expectations and support return-to-work programs.

Post Incident Best Practices

1. Complete an internal incident investigation immediately
2. Report the claim within 0-3 days
3. Provide employees with medical provider information
4. Help employees understand the process and minimize uncertainty
5. Keep the conversation constructive – focus on what happened and future prevention, not blame

Instructions

WSDA WASHINGTON STATE DENTAL ASSOCIATION

<Insert Company Name>
<address>
<address>
<phone number>

Employee Incident Procedure Packet

1. Report incident to your supervisor immediately.
2. Fill out the attached Employee Incident Report.
3. If you are **NOT** seeking treatment from a medical provider give the completed Employee Incident Report to the <practice/office workers comp manager>.
4. If you **ARE** going to seek treatment from a medical provider,
   a. give the completed Employee Incident Report to the <practice/office workers comp manager>
   b. Please also discuss light duty options available with your employer.
   c. **It is also very important** to inform the medical provider that your employer is **insured through the Department of Labor and Industries (L&I)**, and inform the medical provided that your employer has a "no time loss" philosophy and can provide transitional duty work available for any restriction.

   We recommend you see (although you can see a provider of your choice):

<Insert name of nearest medical provider>
<address>
<address>
<phone number>

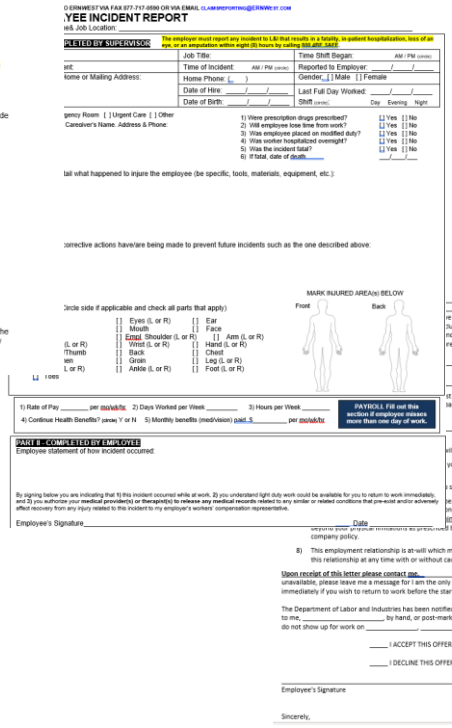
If it is after hours and immediate medical attention is necessary, please see the nearest available medical provider.

5. You must return to work immediately after your doctor's appointment with the completed documentation and deliver it to your <practice/office workers comp manager>.
6. If restricted from work, the <practice/office workers comp manager>will present you with a job offer letter and a copy of the completed Modified Duty Job Description signed by the medical provider.
7. You must check in with the <practice/office workers comp manager> after each doctor's appointment.
8. You must schedule all treatment outside of your scheduled work periods.

I have read and understand this incident reporting procedure listed above, **AND** I agree to follow the terms and physical restrictions of my release both at work and outside of work to help facilitate my recovery.

Employee Signature: _____

Incident Report



O ERNWEST VIA FAX 877-717-3690 OR VIA EMAIL CLAIMSREPORTING@ERNWEST.COM

YEE INCIDENT REPORT

ork Location: _____

PLETED BY SUPERVISOR

The employer must report any incident to L&I that results in a fatality, in-patient hospitalization, loss of an eye, or an amputation within eight (8) hours by calling 800.321.2627.

	Job Title:	Time Shift Began: AM / PM (circle)
ent:	Time of Incident: AM / PM (circle)	Reported to Employer: ____/____/____
Home or Mailing Address:	Home Phone: (_ _)	Gender: [ ] Male [ ] Female
	Date of Hire: ____/____/____	Last Full Day Worked: ____/____/____
	Date of Birth: ____/____/____	Shift (circle): Day Evening Night

gency Room [ ] Urgent Care [ ] Other:
Caregiver's Name, Address & Phone:

1) Were prescription drugs prescribed? [ ] Yes [ ] No
2) Will employee lose time from work? [ ] Yes [ ] No
3) Was employee placed on modified duty? [ ] Yes [ ] No
4) Was worker hospitalized overnight? [ ] Yes [ ] No
5) Was the incident fatal? [ ] Yes [ ] No
6) If fatal, date of death: ____/____/____

tail what happened to injure the employee (be specific, tools, materials, equipment, etc.):

orrective actions have/are being made to prevent future incidents such as the one described above:

MARK INJURED AREA(s) BELOW

Front Back

ircle side if applicable and check all parts that apply)

	[ ] Eyes (L or R)	[ ]	Ear
	[ ] Mouth	[ ]	Face
	[ ] Empl. Shoulder (L or R)	[ ]	Arm (L or R)
(L or R)	[ ] Wrist (L or R)	[ ]	Hand (L or R)
/Thumb	[ ] Back	[ ]	Chest
ven	[ ] Groin	[ ]	Leg (L or R)
L or R)	[ ] Ankle (L or R)	[ ]	Foot (L or R)

[ ] Toes

1) Rate of Pay _____ per mo/wk/hr 2) Days Worked per Week _____ 3) Hours per Week _____
4) Continue Health Benefits? (circle) Y or N 5) Monthly benefits (med/vision) paid $_____ per mo/wk/hr

PAYROLL Fill out this section if employee misses more than one day of work.

PART II - COMPLETED BY EMPLOYEE
Employee statement of how incident occurred:

By signing below you are indicating that 1) this incident occurred while at work, 2) you understand light duty work could be available for you to return to work immediately, and 3) you authorize your medical provider(s) or therapist(s) to release any medical records related to any similar or related conditions that pre-exist and/or adversely affect recovery from any injury related to this incident to my employer's workers' compensation representative.

Employee's Signature _____ Date

Job Offer Letter

_____ ___, 20__

_____ that will accommodate your current
_____. This job is available on a reasonably continuous basis and
e medical findings and associated restrictions. The details of this offer are subject
lude verification of employment eligibility and drug testing. A detailed
nding medical provider on _____ ___, 20__, has been attached
e not limited to:

_____ ___, 20__ at ___:___ am/pm (circle) at the following

t until ___:___ am/pm _____ through _____. You will be
ased on your pattern of employment established prior to the date of your

____ who will act as your direct supervisor, and has been advised of your

ill receive benefits in accordance with our company policy.
you must schedule them outside of work hours unless approved by a

satisfactorily complete assigned duties not previously performed.
erformance of your duties; you are to report them to
n as possible. You should not take it upon yourself to perform any task
ised by your attending medical provider. Should you voluntarily work
by your attending physician, actions will/may be taken in accordance to
company policy.

8) This employment relationship is at-will which means both we as the employer and you as the employee are free to end this relationship at any time with or without cause.

Upon receipt of this letter please contact me, _____, at (___) ___-_____ to accept or decline this job offer. If I am unavailable, please leave me a message for I am the only authorized individual that may accept your decision. This position is available immediately if you wish to return to work before the start date.

The Department of Labor and Industries has been notified of this job offer. Please check the appropriate box below and return this letter to me, _____, by hand, or post-marked before _____, ____, 20__, at ___:___ am/pm. If you do not show up for work on _____, _____, ____, 20__ at ___:___ am/pm your claim benefits may be affected.

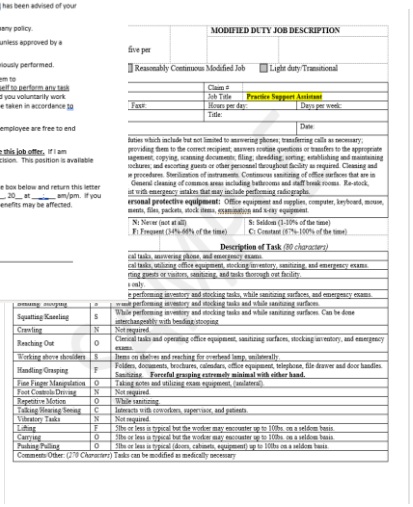
_____ I ACCEPT THIS OFFER

_____ I DECLINE THIS OFFER (may affect L&I time loss benefits)

Employee's Signature Date

Sincerely,

Mod Duty Job Desc



MODIFIED DUTY JOB DESCRIPTION

five per

Reasonably Continuous Modified Job Light duty/Transitional

	Claim #
	Job Title: **Practice Support Assistant**
Fax#:	Hours per day: Days per week:
	Title:
	Date:

ities which include but not limited to answering phones; transferring calls as necessary; providing them to the correct recipient; answers routine questions or transfers to the appropriate agement; copying, scanning documents; filing; shredding; sorting; establishing and maintaining rochures; and escorting guests or other personnel throughout facility as required. Cleaning and e procedures. Sterilization of instruments. Continuous sanitizing of office surfaces that are in General cleaning of common areas including bathrooms and staff break rooms. Re-stock, st with emergency intakes that may include performing radiographs.

ersonal protective equipment: Office equipment and supplies, computer, keyboard, mouse, ments, files, packets, stock items, examination and x-ray equipment.

N: Never (not at all) S: Seldom (1-10% of the time)
F: Frequent (34%-66% of the time) C: Constant (67%-100% of the time)

Description of Task *(80 characters)*

cal tasks, answering phone, and emergency exams.
cal tasks, utilizing office equipment, stocking/inventory, sanitizing, and emergency exams.
ting guests or visitors, sanitizing, and tasks thorough out facility.
only.
e performing inventory and stocking tasks, while sanitizing surfaces, and emergency exams.

		e while performing inventory and stocking tasks and while sanitizing surfaces.
Squatting/Kneeling	S	While performing inventory and stocking tasks and while sanitizing surfaces. Can be done interchangeably with bending/stooping
Crawling	N	Not required.
Reaching Out	O	Clerical tasks and operating office equipment, sanitizing surfaces, stocking/inventory, and emergency exams.
Working above shoulders	S	Items on shelves and reaching for overhead lamp, unilaterally.
Handling/Grasping	F	Folders, documents, brochures, calendars, office equipment, telephone, file drawer and door handles. Sanitizing. **Forceful grasping extremely minimal with either hand.**
Fine Finger Manipulation	O	Taking notes and utilizing exam equipment. (unilateral).
Foot Controls/Driving	N	Not required.
Repetitive Motion	O	While sanitizing.
Talking/Hearing/Seeing	C	Interacts with coworkers, supervisor, and patients.
Vibratory Tasks	N	Not required.
Lifting	F	5lbs or less is typical but the worker may encounter up to 10lbs. on a seldom basis.
Carrying	O	5lbs or less is typical but the worker may encounter up to 10lbs. on a seldom basis.
Pushing/Pulling	O	5lbs or less is typical (doors, cabinets, equipment) up to 10lbs on a seldom basis.
Comments/Other: *(270 Characters)*		Tasks can be modified as medically necessary

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Incident Reporting Packet

WSDA WASHINGTON STATE DENTAL ASSOCIATION

<Insert Company Name>

<address>
<address>
<phone number>

Employee Incident Procedure Packet

1. Report incident to your supervisor immediately.
2. Fill out the attached Employee Incident Report.
3. If you are **NOT** seeking treatment from a medical provider give the completed Employee Incident Report to the <practice/office workers comp manager>.
4. If you **ARE** going to seek treatment from a medical provider,
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   b. Please also discuss light duty options available with your employer.
   c. **It is also very important** to inform the medical provider that your employer is **insured through the Department of Labor and Industries (L&I)**, and inform the medical provided that your employer has a "no time loss" philosophy and can provide transitional duty work available for any restriction.

   We recommend you see (although you can see a provider of your choice):

   <Insert name of nearest medical provider>
   <address>
   <address>
   <phone number>

   If it is after hours and immediate medical attention is necessary, please see the nearest available medical provider.

5. You must return to work immediately after your doctor's appointment with the completed documentation and deliver it to your <practice/office workers comp manager>.
6. If restricted from work, the <practice/office workers comp manager>will present you with a job offer letter and a copy of the completed Modified Duty Job Description signed by the medical provider.
7. You must check in with the <practice/office workers comp manager> after each doctor's appointment.
8. You must schedule all treatment outside of your scheduled work periods.

I have read and understand this incident reporting procedure listed above, **AND** I agree to follow the terms and physical restrictions of my release both at work and outside of work to help facilitate my recovery.

Employee Signature: _____
Date: _____

Instructions – Part 1:

1. Report to direct supervisor
2. Fill out incident report
3. Determine need for medical appointment
4. Medical treatment suggestion – NOT direction

Part 2 of this is covered in the Return-to-Work portion of this presentation

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SUBMIT COPY TO ERN*WEST* VIA FAX 877-717-0590 OR VIA EMAIL CLAIMSREPORTING@ERNWEST.COM

EMPOYEE INCIDENT REPORT

Company Name& Job Location: _____

PART I - COMPLETED BY SUPERVISOR The employer must report any incident to L&I that results in a fatality, in-patient hospitalization, loss of an eye, or an amputation within eight (8) hours by calling 800 4BE SAFE.

Employee:	Job Title:	Time Shift Began: AM / PM (circle)
Date of Incident:	Time of Incident: AM / PM (circle)	Reported to Employer: ____/____/____
Employee's Home or Mailing Address:	Home Phone: (_)	Gender: [ ] Male [ ] Female
	Date of Hire: ____/____/____	Last Full Day Worked: ____/____/____
	Date of Birth: ____/____/____	Shift (circle): Day Evening Night

Seen by: [ ] Emergency Room [ ] Urgent Care [ ] Other
Treating Caregiver's Name. Address & Phone:

1) Were prescription drugs prescribed? [ ] Yes [ ] No
2) Will employee lose time from work? [ ] Yes [ ] No
3) Was employee placed on modified duty? [ ] Yes [ ] No
4) Was worker hospitalized overnight? [ ] Yes [ ] No
5) Was the incident fatal? [ ] Yes [ ] No
6) If fatal, date of death ___/___/___

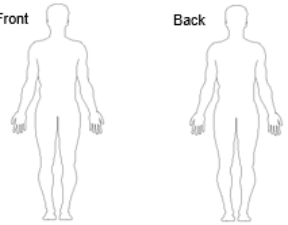
Describe in detail what happened to injure the employee (be specific, tools, materials, equipment, etc.):

What specific corrective actions have/are being made to prevent future incidents such as the one described above:

Part of Body (Circle side if applicable and check all parts that apply)

[ ] Head	[ ] Eyes (L or R)	[ ] Ear
[ ] Nose	[ ] Mouth	[ ] Face
[ ] Neck	[ ] Shoulder (L or R)	[ ] Arm (L or R)
[ ] Elbow (L or R)	[ ] Wrist (L or R)	[ ] Hand (L or R)
[ ] Finger/Thumb	[ ] Back	[ ] Chest
[ ] Abdomen	[ ] Groin	[ ] Leg (L or R)
[ ] Knee (L or R)	[ ] Ankle (L or R)	[ ] Foot (L or R)
[ ] Toes		

MARK INJURED AREA(s) BELOW



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PAYROLL Fill out this section if employee misses more than one day of work.

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Employee statement of how incident occurred:

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Employee's Signature_____ Date _____

Form Completed By: Phone: Date: Title:

Incident Report:

In one page, the ERNwest incident report provides all of the basic information necessary for:

- Reporting to L&I
- OSHA 300 reporting
- Incident investigation
- Claims Management

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SUBMIT COPY TO ERN*WEST* VIA FAX 877-717-0590 OR VIA EMAIL CLAIMSREPORTING@ERNWEST.COM

EMPLOYEE INCIDENT REPORT

Company Name & Location: _____

PART I - COMPLETED BY SUPERVISOR

The employer must report any incident to L&I that results in a fatality, in-patient hospitalization, loss of an eye, or an amputation within eight (8) hours by calling 800.4BE.SAFE.

Employee:	Job Title:	Time Shift Began: AM / PM (circle)
Date of Incident:	Time of Incident: AM / PM (circle)	Reported to Employer: _____/_____/_____
Employee's Home or Mailing Address:	Home Phone: ( )	Gender: [ ] Male [ ] Female
	Date of Hire: _____/_____/_____	Last Full Day Worked: _____/_____/_____
	Date of Birth: _____/_____/_____	Shift (circle): Day Evening Night

Seen by:

[ ] Emergency Room [ ] Urgent Care [ ] Other

Treating Caregiver's Name, Address & Phone:

1) Were prescription drugs prescribed? [ ] Yes [ ] No
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6) If fatal, date of death ___/___/___

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Part of Body (Circle side if applicable and check all parts that apply)

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[ ] Nose	[ ] Mouth	[ ] Face
[ ] Neck	[ ] Shoulder (L or R)	[ ] Arm (L or R)
[ ] Elbow (L or R)	[ ] Wrist (L or R)	[ ] Hand (L or R)
[ ] Finger/Thumb	[ ] Back	[ ] Chest
[ ] Abdomen	[ ] Groin	[ ] Leg (L or R)
[ ] Knee (L or R)	[ ] Ankle (L or R)	[ ] Foot (L or R)
[ ] Toes		

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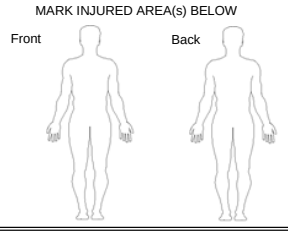

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PAYROLL Fill out this section if employee misses more than one day of work.

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Employee's Signature_____ Date _____

Form Completed By: _____ Phone: _____ Date: _____ Title: _____

OSHA Log case number _____ (transfer the case number from the OSHA 300 log after recording the case)

Notification:

Employers must report to L&I by calling **1-800-423-7233** if:

- Death or in-patient hospitalization of any employee (within 8 hours)
- Any non-hospitalized amputation or loss of eye (within 24 hours)

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SUBMIT COPY TO ERN*WEST* VIA FAX 877-717-0590 OR VIA EMAIL CLAIMSREPORTING@ERNWEST.COM

EMPLOYEE INCIDENT REPORT

Company Name & Location: _____

PART I - COMPLETED BY SUPERVISOR

The employer must report any incident to L&I that results in a fatality, in-patient hospitalization, loss of an eye, or an amputation within eight (8) hours by calling 800.4BE.SAFE.

Employee:	Job Title:	Time Shift Began: AM / PM (circle)
Date of Incident:	Time of Incident: AM / PM (circle)	Reported to Employer: _____/_____/_____
Employee's Home or Mailing Address:	Home Phone: ( )	Gender: [ ] Male [ ] Female
	Date of Hire: _____/_____/_____	Last Full Day Worked: _____/_____/_____
	Date of Birth: _____/_____/_____	Shift (circle): Day Evening Night

Seen by: [ ] Emergency Room [ ] Urgent Care [ ] Other
Treating Caregiver's Name, Address & Phone:

1) Were prescription drugs prescribed? [ ] Yes [ ] No
2) Will employee lose time from work? [ ] Yes [ ] No
3) Was employee placed on modified duty? [ ] Yes [ ] No
4) Was worker hospitalized overnight? [ ] Yes [ ] No
5) Was the incident fatal? [ ] Yes [ ] No
6) If fatal, date of death ___/___/___

Describe in detail what happened to injure the employee (be specific, tools, materials, equipment, etc.):

What specific corrective actions have/are being made to prevent future incidents such as the one described above:

Part of Body (Circle side if applicable and check all parts that apply)

[ ] Head
[ ] Nose
[ ] Neck
[ ] Elbow (L or R)
[ ] Finger/Thumb
[ ] Abdomen
[ ] Knee (L or R)
[ ] Toes
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[ ] Mouth
[ ] Shoulder (L or R)
[ ] Wrist (L or R)
[ ] Back
[ ] Groin
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[ ] Ear
[ ] Face
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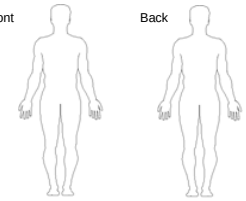
MARK INJURED AREA(s) BELOW

Front Back



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PAYROLL Fill out this section if employee misses more than one day of work.

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Employee statement of how incident occurred:

By signing below you are indicating that **1)** this incident occurred while at work, **2)** you understand light duty work could be available for you to return to work immediately, and **3)** you authorize your **medical provider(s) or therapist(s) to release any medical records** related to any similar or related conditions that pre-exist and/or adversely affect recovery from any injury related to this incident to my employer's workers' compensation representative.

Employee's Signature_____ Date _____

Form Completed By: _____ Phone: _____ Date: _____ Title: _____

OSHA Log case number _____ (transfer the case number from the OSHA 300 log after recording the case)

OSHA 301:

The form has all information required by the OSHA 301 record keeping requirement. The OSHA 301 is the backup/detail to the OSHA 300 form that is required to be posted annually by many employers.

Exempt employers:

- Under 10 employees
- Low hazard industry group

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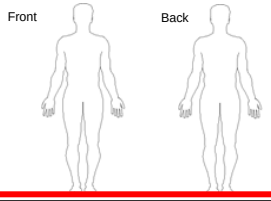

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Employee's Signature_____ Date _____

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Investigation:

- Goal is to objectively identify the cause of the injury, NOT to blame.
- The intensity of your investigation should match the circumstances of the incident (e.g. minor burn v. slip and fall with a back injury).
- Use data collected from the investigation to prevent future accidents by training employees exposed to the same hazard.
- Data collected from the investigation can be used to contest questionable claims.

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Investigation Guidelines

Incident Analysis Guidelines

The purpose of an incident analysis is to find the cause of an incident and prevent further occurrences, not to fix blame. An unbiased approach is necessary to obtain objective findings.

- If possible, interview injured workers at the scene of the incident and "walk through" a re-enactment. Be careful not to repeat the act that caused the injury.
- Privacy is important during interviews. Interview witnesses one at a time. Talk with anyone who has knowledge of the incident, even if they did not actually witness the mishap.
- Record names, addresses, and statements of witnesses. Consider taking signed, dated statements if facts are unclear or an element of controversy exists.
- In major injuries, use sketches, diagrams and photos to document details graphically. Take measurements when appropriate.
- Identify the circumstances preceding and surrounding the injury--what were underlying and contributing causes, as well as immediate causes?
- What physical hazards existed at the time of the incident, such as unprotected openings, poor housekeeping, slippery surfaces, protruding nails, etc.?
- Were defective tools, equipment or materials provided to or used by the employee(s)?
- Was personal protective equipment (PPE) provided? Was PPE defective, not used, or used improperly? Was PPE needed?
- Did unsafe work practices contribute to the injury, including improper lifting, handling of materials or equipment failure?
- What safety rules or safety training might have prevented the incident?
- If a third party or defective product contributed to the accident, save any evidence. It could be critical to the recovery of claim costs.

Incident Analysis Discussions:

Did you discuss with the injured employee's supervisor the details of the incident and obtain names of witnesses?	☐ Yes ☐ No
Did you get statements from all witnesses with information (directly or indirectly) concerning incident/injury?	☐ Yes ☐ No
Did you analyze the safety measures that were in force at the time of injury?	☐ Yes ☐ No
Did you analyze whether or not equipment or mechanism failure, or another person/party (contractor, etc.) was a factor in the incident/injury?	☐ Yes ☐ No
Have you reviewed and evaluated all documentation to identify the cause of the incident (including the circumstances preceding the injury)?	☐ Yes ☐ No
Have you taken steps to implement a solution so this type of incident does not occur again, such as training or engineering controls?	☐ Yes ☐ No
Did you report this incident to Employer Resources Northwest (ERNWest)?	☐ Yes ☐ No
Was employee admitted to hospital overnight? Was there a fatality, loss of an eye or amputation? **If so, you MUST report to incident to LNI 800-4BE-SAFE AND prepare for possible LNI Inspection.**	☐ Yes ☐ No
Did you enter this incident/injury on the OSHA 300 Log (if applicable)?	☐ Yes ☐ No

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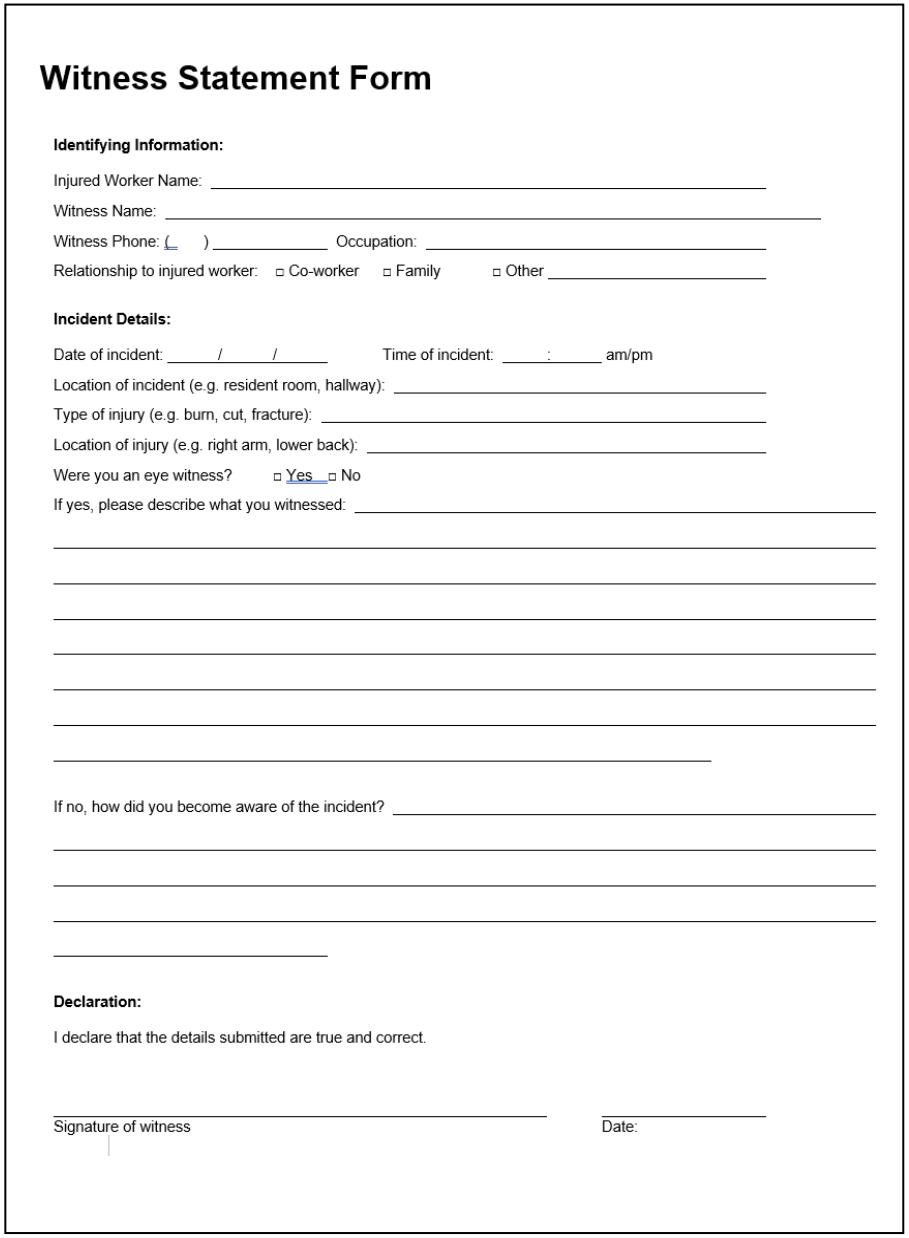

Witness Statement Form

Identifying Information:

Injured Worker Name: _____

Witness Name: _____

Witness Phone: ( ) _____ Occupation: _____

Relationship to injured worker: ☐ Co-worker ☐ Family ☐ Other _____

Incident Details:

Date of incident: ____/____/____ Time of incident: ____:____ am/pm

Location of incident (e.g. resident room, hallway): _____

Type of injury (e.g. burn, cut, fracture): _____

Location of injury (e.g. right arm, lower back): _____

Were you an eye witness? ☐ Yes ☐ No

If yes, please describe what you witnessed: _____

If no, how did you become aware of the incident? _____

Declaration:

I declare that the details submitted are true and correct.

_____ _____

Signature of witness Date:

Witness Statement

- Not necessary on all incidents
- Helpful when injured employee's recollection is murky, lacks details or is questionable
- Obtain in writing as quickly as possible after the incident.

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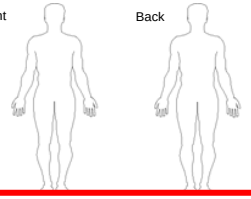

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Employee's Signature_____ Date _____

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OSHA Log case number _____ (transfer the case number from the OSHA 300 log after recording the case)

Wage Info:

- Wage information helps both your ERNwest claims manager and the Department of Labor and Industries claims manager provide timely assistance in getting claims allowed and closed.
- Fill this out if the employee is expected to miss more than one day of work.

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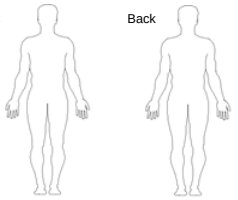

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Employee's Signature_____ Date _____

Form Completed By: _____ Phone: _____ Date: _____ Title: _____

OSHA Log case number _____ (transfer the case number from the OSHA 300 log after recording the case)

Employee:

- Have the employee write how the injury occurred
- ERNwest's form has a release which assists in claims management
- Allows claims management to compare how the injury occurred to that which is reported to L&I

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Questions

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Return to Work

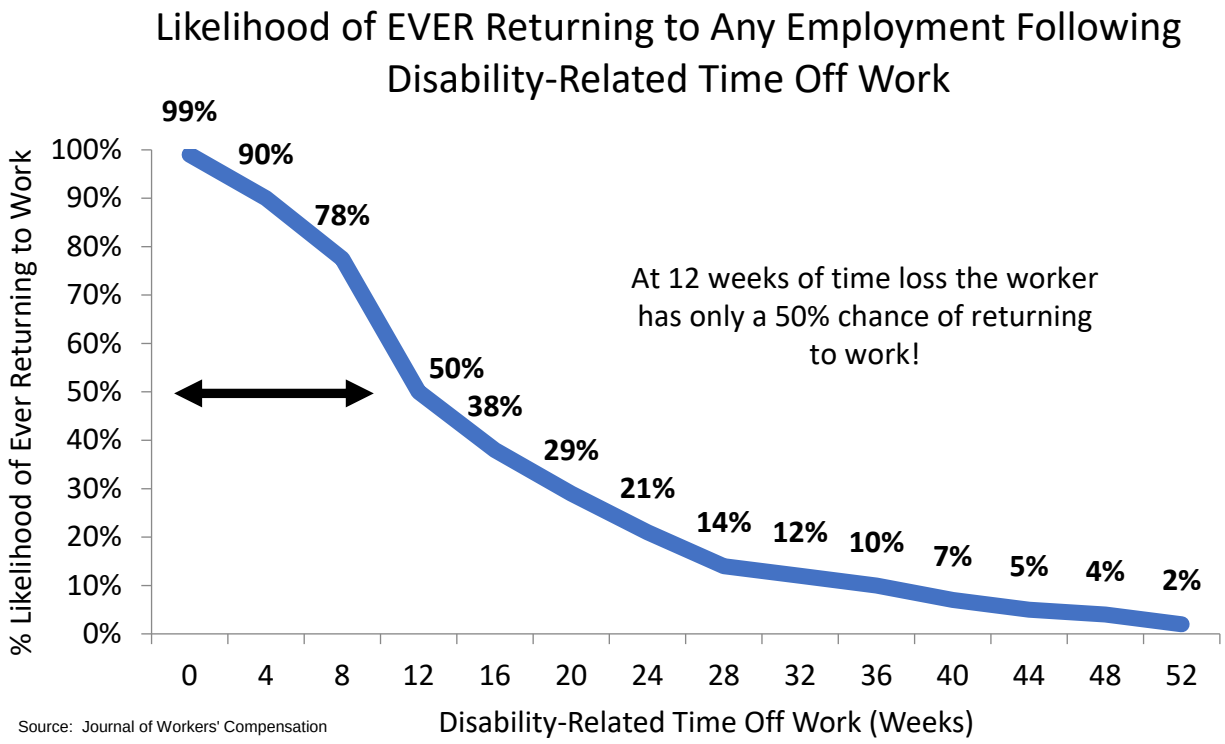
If you do nothing else to manage your workers' compensation program…

If you have a workplace injury that results in an employee being restricted from their regular job **the one thing you must do is return them to work as safely and quickly as possible** even if their work restrictions are extremely limiting.

Why Return to Work?

If you do not return an injured employee to work in a quick and safe manner, you are:

- “Telegraphing” to the injured employee and medical provider you don’t care about them.
- Abdicating control of the claim to the employee, the medical provider and L&I, none of which have your company’s interest in mind.
- Exponentially increasing the cost, time and complexity associated with the injury claim.


Likelihood of EVER Returning to Any Employment Following Disability-Related Time Off Work
% Likelihood of Ever Returning to Work
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
99%
90%
78%
50%
38%
29%
21%
14%
12%
10%
7%
5%
4%
2%
At 12 weeks of time loss the worker has only a 50% chance of returning to work!
0
4
8
12
16
20
24
28
32
36
40
44
48
52
Disability-Related Time Off Work (Weeks)
Source: Journal of Workers' Compensation

Benefits of Return to Work (RTW)

- The employer retains maximum control of the claim.
- Maintains eligibility for medical only discount on the claim and claims free discount on your account
- Disincentivizes fraudulent claims
- Prevents disability conviction
- Develops and sustains momentum toward closure
- Stay at Work reimbursements

Types of Return to Work (RTW)

1. Full Duty Release: When a worker is given a full release to work and informal/formal return to work is not necessary.
2. Informal: When a worker has claim related restrictions and returns to light duty with a verbal agreement to accommodate. There is no legal protection from indemnity if the worker stops showing up, is terminated for cause, etc.
3. Formal: When a written job offer is extended to a worker with claim related restrictions. This protects your company from undue compensation benefits.

Use “Kept On Salary” with RTW

- It is a bridge between an employee being completely restricted from work and RTW in a light/modified job.
- Helps to keep your claim costs down by ...
  - Eliminating indemnity costs from your claims.
  - Maintaining the medical only discount, which eliminates the first $3,450 of the claim costs applied to your rate.
- Keeps lines of communication open with your employee, which improves your control.

Stay at Work Program - Wage & Expense Reimbursement

The Stay at Work program that is run by L&I is designed to incentivize you to return your injured employees to work as safely and quickly as possible. The programs benefits are:

- Reimburse up to 50% of modified duty wage for up to 66 days, up to a maximum of $10,000 per claim.
- Training fees or materials up to $1,000 per claim.
- Tools/equipment up to $2,500 per claim.
- Clothing up to $400 per claim

Requirements

- Medically approved job description
- Medical Provider's description of the worker's restrictions.
- Payroll records/Time Cards
- Completed Stay at Work Wage application
- Itemized receipts (training/materials/clothing)

Key Points

Prevention

But….when a claim happens:

- ERNwest is here to help
- Report the Incident Quickly to ERNwest
- Plan ahead - identify modified/light duty jobs in your clinic
- Return your injured worker as quickly as possible according to their restrictions
- Use KOS and RTW strategies to support your employee and reduce costs

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