

Short and Long-term Disability and Workers' Compensation Health

Care Programs: Management Project at

Georgetown University Hospital

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Acknowledgments

I wish to express my sincere thanks and appreciation to the following individuals for their support and guidance in the completion of this project:

Ms. Sharon M. Flynn Hollander, Hospital Chief
Executive, Georgetown University Hospital

Mr. Dennis M. Rogers, Claims Manager, The Office of
Risk Management, Georgetown University

Ms. Linda Bundy Williams, Director, Faculty & Staff
Benefits Office, University Human Resources, Georgetown
University

Ms. Ellen Shew, Data Analyst, The Office of Risk
Management, Georgetown University

Their tireless effort and patience allowed me to gain tremendous insight and knowledge for two critical programs that affect the majority of Americans.

Abstract

The financial challenges associated with the managed care environment in the health care industry have resulted in significant emphasis on cost reduction and improvement in business operations and strategies. Recent acquisition discussions between Georgetown University Medical Center and MedStar provide an opportunity to reengineer the Workers' Compensation and Short and Long-Term Disability Programs. Reengineering efforts should be focused on improving services to the employees and reducing the direct and indirect costs associated with these programs.

The literature and existing studies support the introduction of a managed care model focused on case management and medical management to reduce direct and indirect costs. The Workers' Compensation and Disability Programs can be organizationally consolidated with the Employee Health Services providing medical management.

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Introduction

Background Georgetown University Medical Center (GUMC) is a nonprofit, university owned and operated health care organization located within the District of Columbia (DC). Classified as a large Academic Healthcare Center (AHC), GUMC received accreditation as a medical center from the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) for the first time in September of 1999. Prior to 1999, Georgetown University Hospital was the only component of GUMC accredited by JCAHO. GUMC strives to provide high quality, sensitive, cost-effective health care services to all patients consistent with the Jesuit tradition of the University.

The principal organizational components of GUMC consist of the School of Medicine, the School of Nursing, the Georgetown University Hospital, the Faculty Practice Group, the Community Practice Network, and other Specialized Research Centers/ Institutes. The Georgetown University Medical Center Organizational Chart is presented in Appendix A.

Georgetown University Hospital is licensed for 535 beds, currently operating at 330 beds and 69 bassinets. There are approximately 1,900 hospital employees with 1,200 physicians on medical staff (450 are employed by

Georgetown, the remaining are in private practice).

Additionally, there are 450 residents in training.

Currently, GUMC and MedStar (Parent organization of Washington Hospital Center) are concluding merger/acquisition discussions for the hospital component. The organizations have completed the due diligence phase of the merger/partnership. The existence of the merger/partnership affected the scope and outcome of this study. As such, the impact of the merger will be addressed in the final analysis.

Conditions which Prompted the Study The Balanced Budget Act of 1997, continued technology advances, and the advancement of managed care within the health care industry all have created a business environment focused on cost reduction strategies. Many AHCs are struggling to maintain their research and educational mission within a health care delivery system focused on implementing managed care philosophies to reduce health care expenditures. Managed care has lowered the utilization of secondary and tertiary services, with fewer admissions and a reduction in the length of stay. The changes within the health care market have resulted in tremendous challenges for AHCs (Solit & Nash, 1997).

The quality of health care delivered at Georgetown is world-renowned. GUMC has enjoyed years of fruitful operation, only recently experiencing financial difficulties. To remain competitive and viable, GUMC has focused their efforts on cost reduction strategies while maintaining quality service and care. Through cost reduction strategies and the implementation of sound business practices, many policies and procedures are under review and revision to reduce overhead and costs associated with the delivery of care.

The pressure associated with staff reduction efforts has resulted in a tumultuous environment, with the emergence of a significant turnover ratio at GUMC. Additionally, the Washington DC area has numerous health care institutions competing for qualified employees within a limited resource pool. The ability to attract and retain qualified employees is directly impacted by disability benefits and workers' compensation practices.

The requirement to reduce operational costs and to maximize the outcomes associated with the expenditures of dwindling resources all play a direct role in this management project. The short and long-term disability and workers' compensation programs at Georgetown University

Hospital indirectly impact employee morale, turnover of personnel, and patient and staff satisfaction.

Statement of the Problem or Question Can managed care techniques be used to consolidate and improve workers' compensation and short and long-term disability programs at Georgetown University Hospital?

Literature Review

The primary goal of the literature review was to explore the workers' compensation health care delivery system and the non-occupational disability management program to identify potential improvements for the existing system at Georgetown University Hospital. The literature review included: (1) an overall review of workers compensation program and disability benefits program; (2) specific requirements of the District of Columbia Workers' Compensation Program; (3) a review of national expenditures and trends, (4) a review of the Workers' Compensation Health Initiative; (5) and finally, a review of current managed care initiatives.

Historically in the U.S., injuries sustained by individuals during employment were governed by the common-law system. During the industrial revolution, it became

necessary to develop an alternative system to protect the individual workers and the employers. In 1902, Maryland was the first state to attempt to enact a workers compensation law in 1902. Not until 1911 was a state, Wisconsin, successful in enacting a workers compensation law that was subsequently ruled constitutional. Now, workers' compensation programs exist in all 50 states, the District of Columbia, in Puerto Rico, and the U.S. Virgin Islands. Additionally, there are two federal workers' compensation programs covering federal government employees, longshoremen, and harbor workers (Robinson, L. G., & Rudd, A., 1995).

Workers' compensation is a form of social insurance. The injured employee receives cash compensation while recovering from work-related injuries and the employee relinquishes his or her right to sue the employer for negligence. The "mutual" protection for the employee and the employer delineates the social contract within workers' compensation programs (Johnson & Lipson, 1996). The compensation is cash payments for lost wages and costs associated with health care. Employers are required to contribute to an insurance fund to provide coverage for all employees (Sultz & Young, 1997).

State-based workers' compensation (WC) insurance is mandatory and benefits are highly regulated. "To be eligible for benefits, a covered employee must have an injury or illness that is "caused or aggravated by employment" or "arises out of or in the course of employment."" (Himmelstein, J., Buchanan, J. L., Dembe, A. E., & Stevens, B, 1999, p 429). WC insurance is accountable for both medical care and lost-wage (indemnity) benefits; which have historically been reimbursed using fee-for-service.

The fee-for-service payment mechanism within WC and the political environment result in conflicting incentives for the patients, providers, the employer, and the insurers. Additionally, the patterns of care within the WC medical care are distinct and different from those seen in typical health insurance plans. Medical care through WC may be accelerated to expedite the return of an employee to work. This capitalizes on reducing the disability benefits through an aggressive return-to-work program. In a typical health plan covering non-occupational injuries and illnesses, there may be a tendency for the insurer to delay or deny medical treatment. These patterns affect the overall delivery of care and the subsequent utilization of

different medical treatments and tests (Himmelstein, J., Buchanan, J. L., Dembe, A. E., & Stevens, B).

Disability Programs are designed to supplement income when an employee is injured or becomes ill as a result of a non-occupational injury or illness. The programs do not provide reimbursement for health care expenditures.

Disability Programs are frequently offered with salary and benefit packages for employees. Sick leave and long-term disability are the most common forms of non-occupational benefit plans. Additionally, short-term disability (salary continuation) is cited as the least common plan among the participants of the American Hospital Association 1996 Health Care Organizations and Loss of Time Programs and Issues Survey.

The difference between disability and WC programs is best observed by reviewing the different cost controls employed by each program. A traditional health insurer seeks cost savings through limiting or denying medical benefits. A state-based WC program accelerates appropriate medical care to shorten the period of disability to reduce the cost of the overall claim. The indemnity included in WC results in substantial claim cost to the employer (Himmelstein, J., Buchanan, J. L., Dembe, A. E., and Stevens, B., 1999, April). Granahan (1997) further explains

the differences are due to the difference in program goals and benefit levels. Workers' compensation programs focus on providing and paying for all the medical services required to return the person to work. Whereas, a typical group health program only delivers those services included in the contract of benefits.

WC programs are state-based and the programs share mutual requirements. However, there are subtle differences state to state and these differences should be noted for the specific region or state in which the business entity exists. Georgetown University Hospital, located in the District of Columbia, complies with the District of Columbia's WC program title 36, §§ 36-301-345.

Title 36, §§ 36-301-345 includes provisions that allow the employees "the right to choose an attending physician to provide medical care ..." (§ 36-307(b)(3)). This provision allows the employee to choose the initial provider. This is a key element of the DC law in that it may influence the ability to introduce managed care techniques within the WC and Disability Benefits programs. As a result of WC statutory requirements and the existing medical care environment, the expenditures for workers' compensation have grown substantially.

In 1997 the national expenditures for workers' compensation was estimated to be \$70 billion and it's expected to exceed \$120 billion by the end of year 2000 (Norman, 1997). The escalation of workers compensation costs has occurred throughout the United States since the late 1980s and continuing through the 1990s (Dembe & Himmelstein, 1997).

The escalation in the medical component of workers compensation can be attributed to medical providers forced to "cost shift" and the tendency of some employees to fraudulently claim work related medical costs. "Cost shifting" occurs when the provider charges higher rates to workers compensation insurers as compared to group health insurers (Dembe & Himmelstein, 1997). A study conducted by Durbin and Corro (1996) indicated "the prices charged workers compensation claims are not systematically different from prices observed generally. Thus, we find no support for price discrimination hypothesis." (Durbin, D. L., & Corro, D., 1996, p. 21). This contradicts the theory of "cost shifting".

The rapid cost escalation experienced within workers' compensation health care during the 1980s and 1990s resulted in the establishment of the Workers' Compensation Health Initiative (WCHI) in October 1995 by the Robert Wood

Johnson Foundation (RWJF). RWJF provided grants to promote and evaluate new models and approaches to the delivery of workers' compensation health care. State government agencies, employers, labor unions, insurers, health care providers, and researchers were all eligible to submit proposals to RWJF (Dembe, A. E., Himmelstein, J. S., Stevens, B. A., & Beachler, M. P., 1997, July/ August).

RWJF awarded 10 grants totaling \$3 million in November 1996. The proposals covered six broad approaches or innovative models to contain costs and improve the quality of workers' compensation health care. The six approaches included: (1) provider networks; (2) state-approved managed care programs; (3) case management; (4) twenty-four hour plans; (5) alternative arrangements; and (6) education and communication (Dembe, A. E., Himmelstein, J. S., Stevens, B. A., & Beachler, M. P. (1997, July/August).

The Provider Network Model typically incorporates the development of physician networks capitalizing on a variety of managed care elements. The managed care elements include discounted fees, case management, the use of treatment guidelines, utilization review, bill review, and other cost containment programs (Dembe, A. E., Himmelstein, J. S., Stevens, B. A., & Beachler, M. P., 1997, July/August).

Preliminary studies indicate the implementation of managed care strategies within workers' compensation health care have resulted in cost savings. There is concern however, regarding the effect on access and quality of care delivered to workers within the workers' compensation health care model (Dembe, 1998).

State-Approved Managed Care Models are in existence throughout the United States with variations regarding the mandatory components including utilization review, bill review, and treatment guidelines directed towards workers' compensation health care (Dembe, A. E., Himmelstein, J. S., Stevens, B. A., & Beachler, M. P. (1997, July/August).

One of the most prominent models incorporated to contain costs and improve the quality of the care provided within workers' compensation (WC) health care is case management. The case management strategy relies heavily on close supervision throughout the medical treatment, rehabilitation, and any subsequent therapy and vocational training. Case management strategies are suited to provide coordination and communication among the employer, the injured employee, physician, therapists, insurers, lawyers, WC Commissioners, and others. "Many organizations are developing new models of workers' compensation-oriented case management that bridge the demands for medical case

oversight, disability management, patient advocacy, communications, and claims administration" (Dembe, A. E., Himmelstein, J. S., Stevens, B. A., & Beachler, M. P., 1997, July/August, p. 255).

Despite regulatory differences between workers' compensation health care and non-compensation health care, there have been several state and private sponsored initiatives, beginning in 1993, to combine the two programs into twenty-four hour health coverage. Several examples of this strategy include: (1) the Minnesota Health Partnership blends the medical care and disability benefits that were traditionally provided workers' compensation and group health; (2) the State of Maine Bureau of Insurance; and (3) the Electrical Employees Self Insurance Safety Plan in New York State compensation (Dembe, A. E., Himmelstein, J. S., Stevens, B. A., & Beachler, M. P., 1997, July/August).

The twenty-four hour model has lost some momentum with development and research since 1994 partially due to the failure of the Clinton Health Reform Act and a decline in the costs associated with workers' compensation (Dembe, A. E., Himmelstein, J. S., Stevens, B. A., & Beachler, M. P., 1997, July/August). A recent study by Watson Wyatt Worldwide, of Bethesda, Md. and the Washington Business Group on Health reported companies with integrated

disability management programs (workers' compensation, disability, and sick pay programs) facilitated return-to-work efforts, improved productivity, was cost and personnel efficient, and eliminated redundancy. The study additionally indicated over 1/3 of the companies reporting the use of integrated disability management processes failed to track their effectiveness (Fernberg, 1999, February).

The final model or strategy employed focuses on improving education and communication. WCHI reported that several of the proposals they received indicated the cost of providing health care was related to a poor understanding of the workers' compensation system. WCHI funded the Mid-America Coalition on Health Care to support the development of a new reporting form and additional communication techniques for people affected in the Kansas City area (Dembe, A. E., Himmelstein, J. S., Stevens, B. A., & Beachler, M. P., 1997, July/August, p. 255). This management project will focus on the managed care initiatives to improve the two programs at Georgetown University Hospital.

Managed Care Initiatives. Recent trends within the workers compensation health care deliver market include managed care techniques designed to curb the rising costs

associated with work-related injuries. Several of those managed care techniques include the use of Health Maintenance Organizations (HMOs), concurrent utilization review (UR) and Preferred Provider Organizations (PPOs) (Browne & Anderson, 1997).

Bernacki and Tsai reported in 1996 results of a four-year study implementing managed care techniques and an enhanced loss control program to reduce work related injuries, disabilities, and costs at the Johns Hopkins Self-Insured Workers' Compensation Program (JHWCP). The model at JHWCP incorporated an occupational physician/nurse case-management team to coordinate the entire process. The occupational medicine physicians provided the primary medical care with assistance and support by the nurse case-manager to provide liaison to those specialists used for episodes of care. The specialists were contracted utilizing a preferred provider organization (PPO) to support any specialty services. Appendix B represents the workers' compensation management system at Johns Hopkins.

The savings resulting from implementing managed care techniques for workers' compensation were favorable and likely to be duplicated even in those states that allow employees freedom of choice regarding selection of physician on the initial and subsequent treatment.

Additionally, favorable results included: (1) a reduction in the overall number of lost-time claims over the four years was attributed to the increase in the use of a modified duty to return employees to jobs instead of placing the employees off work; (2) overall satisfaction was not severely affected; and (3) "environmental-risk management and medical-care management can be integrated to produce substantial savings" (Bernacki & Tsai, 1996, p. 92).

Objectives. The objectives of this management project include: (1) describing the existing policies and procedures for short and long-term disability and workers' compensation programs at GUMC; (2) determine the costs associated with these programs; (3) gain an appreciation of the potential cultural barriers associated with change at GUMC; (4) review short and long-term disability and workers' compensation models within the health care industry and other business industries, identifying trends, changes within these programs, and potential program improvements to GUMC; (5) review the DC workers' compensation regulations; (6) provide alternative business models for existing programs, and (7) recommend program improvements, including an implementation plan.

Method and Procedures

Type of Analysis A case study methodology was employed to accomplish the goals and objectives of the management project. The unit of analysis was the workers' compensation program and short and long-term disability programs currently in use by the Georgetown University Hospital. Although Georgetown University Hospital is a component of Georgetown University Medical Center and both programs are managed and organized at the University Level, the analysis strictly focused on the Hospital component of the programs. The study used statistical data from the workers' compensation program presented for fiscal years 1996 to 1999. The statistical data used for the disability program was from March 1, 1998 to March 4, 2000.

The Risk Management Department, Georgetown University Medical Center, maintains the statistical data for the workers' compensation program using the windows based software program Risk Master™ by Dorn, Inc. Georgetown University, through the use of a Third Party Administrator (TPA) administers the disability program. The University contracts the administration of the benefits program to UNUM®, Inc. UNUM® provides on-line database accessibility to authorized users at the University. The data are downloaded and manipulated in an EXCEL format, allowing for analysis

and industry benchmarking. Additionally, UNUM® offers standardized reports within their product line to facilitate oversight and review of the Disability Program.

Analytic Techniques The study was conducted in three phases. The initial phase, a descriptive case analysis, focused on Georgetown University Hospital's workers' compensation and short and long-term disability programs, specifically on related health care services and return to work. The initial phase defined and described the existing programs, including the costs and outcomes associated with the existing process.

The second phase, an exploratory case study, was accomplished using secondary sources. Existing literature and studies were reviewed to determine if potential alternative models were available and the projected potential outcomes. The final phase included a cross-comparison of the different case models presented in phases I and II. The comparison addressed the potential of implementing managed care techniques to reduce costs associated with workers' compensation and disability programs. Additionally, this report includes recommendations for program improvements and an implementation plan.

Phase I, the descriptive case analysis, included a formal review of documentation available for the programs. It included a thorough review and presentation of information pertaining to the database currently in use by the University to support these two programs on behalf of the Hospital. Additionally, open-ended interviews were conducted with key individuals supporting the two programs.

The primary objective of the open-ended interviews was to get the individuals to talk about the experiences, feelings, opinions, and knowledge regarding the WC health care program and the Disability Program. The interviews were informal allowing for maximum flexibility. Patton (1990) suggests that the open-ended interviews improve the extent to which individual differences and circumstances can be observed among several programs. The quantitative data supplemented by the open-ended interviews provided a complete analysis of the programs.

The key personnel were asked to provide, in addition to clarification of existing processes and procedures, their opinion regarding the current programs focusing on recommendations for improving the existing program. As suggested by Yin (1989), the information provided by key personnel was not overly relied upon. It was corroborated by other sources or evidence. If the case study fails to

corroborate the insights with other information sources, as indicated by Yin (1989), the interviews are a potential weakness associated with this study.

Design Problems A qualitative approach to the analysis of the workers' compensation and short and long-term disability programs limited the ability to make generalized findings beyond Georgetown University Hospital. Although the use of the case study was limited to Georgetown, the management project did gather detailed information well beyond the statistical data currently available within these two programs. There were several design issues that had to be addressed and monitored to maintain overall validity and reliability of the study.

Validity in qualitative inquiry "hinges to a great extent on the skill, competence, and rigor of the person doing the fieldwork" (Patton, 1990, p. 14). Great care was exercised in the completion of the open-ended interview to limit personal biases of the interviewer and interviewee. The validity of the inquiry was improved through the use and presentation of quantitative measures and results available within existing databases.

There are several techniques available for qualitative interviewing including; informal conversational, general

interview guide approach, and standardized open-ended interview. The informal conversational interview was selected because there are not multiple individuals completing the interviews, and there was no overall time limitation. This allowed for multiple interviews with the same individual.

The weaknesses associated with informal conversational interviews, open-ended interviews included: (1) they require a greater amount of time to collect systematic information; (2) they are more open to interviewer effects; (3) the interviewer must be able to interact easily with people in a variety of settings (Patton, 1990). The interviewer built and maintained rapport with the interviewee. The interviewer conveyed empathy and understanding without passing judgement. The intent was to access the perspective of the person being interviewed, capturing the perspectives of the program participants, staff, and others associated with the program.

Results

Workers' Compensation Program. Georgetown University Office of Risk Management is responsible for the administration of the Workers' Compensation Program for Georgetown University Hospital. The Office of Risk Management is geographically located off the main campus, approximately ½ mile from the main hospital complex.

The Workers' Compensation Program is a self-insured fund, providing indemnity and health care benefits for employees either injured or ill as a result of their employment at Georgetown University Hospital. The term indemnity is defined as wage replacement for lost time.

The organizational structure of the Workers' Compensation Program for Georgetown University Hospital is complex and involves multiple individuals, administrators, and departments across the entire university organization. The program is not structured or consolidated under one program manager.

The various departments and programs that ultimately impact the Workers' Compensation Program include the Office of Risk Management, Office of Environmental Health and Safety, Employee Health Service, the Emergency Department, Legal Council, University Employee Benefits Office, and the individual departments within the Hospital.

Externally, the District of Columbia, Office of Workers' Compensation and a Third Party Administrator (TPA), Corvel, Inc. have a direct role in the workers' compensation program. The District of Columbia, Office of Workers' Compensation is the regulatory authority and Corvel, Inc. provides administrative support through the Office of Risk Management. Corvel, Inc reviews medical claims submitted to the University Program for reimbursement under the Workers' Compensation Program establishing the reimbursement rate.

Figure A represents the communication channels associated with the Workers' Compensation Program. The Claims Manager is the focal point for indemnity and health benefits administrative functions with Employee Health Services focusing on the clinical care provided to the employee. Through various communication channels, the employee receives indemnity and health benefits for occupationally related injury and disease.

The Workers' Compensation Program does not have a Return to Work (RTW) Program. Additionally, there is no formal or informal committee established to monitor workers' compensation claims and the program. [A committee was formed to review workers' compensation claims however; the committee has not met in over one year.] Workers'

compensation claims are reviewed by the Hospital on an ad hoc basis.

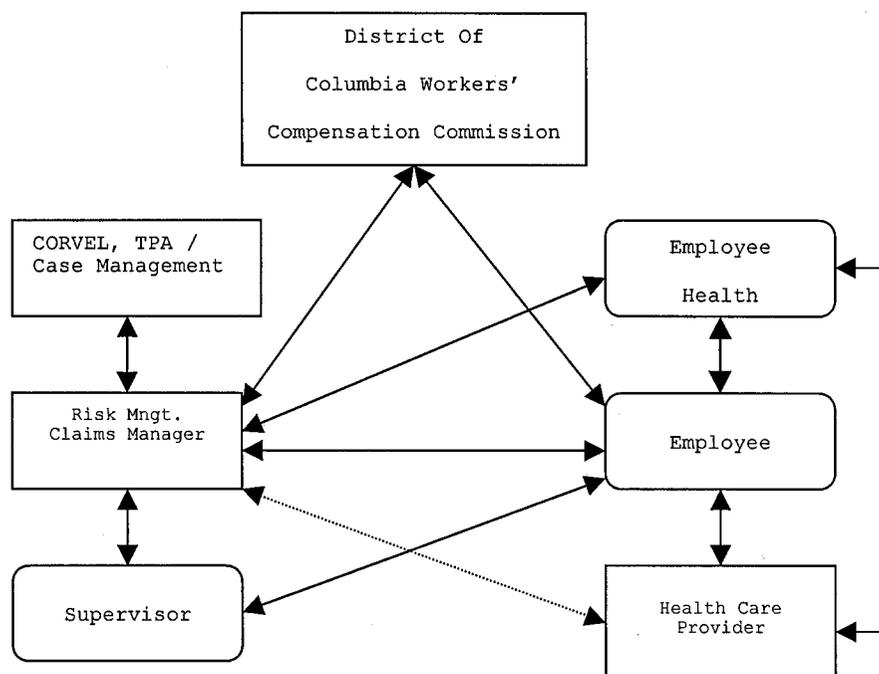


Figure A. Communication channels for the Workers' Compensation Program at Georgetown University Hospital

Claims Process. Appendix C is a flow chart of the claims process for occupational injuries. An employee injured or ill as a result of his/her employment will typically report to Employee Health Services if it is non-emergent. Employee Health Services is a department within the Georgetown University Hospital Organization located within the main hospital complex.

Existing policy encourages the employee to go to the Emergency Department at Georgetown University Hospital if he/she requires immediate care. An employee who is injured or ill as a result of employment is required to notify his/her supervisor as soon as reasonably possible.

The supervisor is responsible for completing the Report to Counsel. The Report to Counsel may or may not be completed by the supervisor as required. The supervisor should complete the Report to Counsel, in those instances when the form is not completed, Employee Health Services completes the Report to Counsel. In addition to the Report to Counsel, "Employer's First Report of Injury or Occupational Disease - Form NO. 8 DCWC" is completed by Employee Health Services and forwarded to the Office of Risk Management. This report is the first formal administrative function within the workers' compensation program.

The Office of Risk Management receives the Report to Counsel and the Employer's First Report of Injury or Occupational Disease and enters the incident/occurrence into Risk Master. Risk Master is a software program used by the Office of Risk Management to maintain data regarding Workers' Compensation claims for the University. All occupationally related injuries and illnesses are reviewed

and tracked by the Office of Risk Management, Claims Manager.

The Claims Manager reviews the report and gathers additional information to gain a thorough understanding of the incident surrounding the injury/illness. The primary goal is ensure the claim meets the District of Columbia's Workers' Compensation requirements and to support the employee and ensure the necessary medical care is provided. This is a critical component of the Workers' Compensation Program.

The Claims Manager makes an initial determination as to the validity of the Workers' Compensation Claim. Based on information provided by the employee, supervisor, healthcare provider and years of experience, the Claims Manager determines the likely action associated with the claim. In the event the Claims Manager does not feel it's a legitimate claim, A Notice of "Controversion" / Memo of Denial of Workers' Compensation Benefits, Form NO. 11 DCWC, is generated and forwarded to the District of Columbia, Office of Workers' Compensation. There have been two contested claims in the last two years.

Descriptive Statistics. Appendix D is a summary of the Workers' Compensation claims for fiscal years 1996 through 1999. The data are listed by diagnosis and

presented in two different categories of types of claims. It is common to track and monitor the claims based on whether indemnity benefits are paid. As such, the data are arranged in this manner. Indemnity benefits are included in the Lost Time category and excluded in the Medical Only category.

A worker's compensation claim may last for several years and accrue for more than one fiscal year. Because of this, claims are tracked by date of occurrence and all related expenses associated with the claim are billed to the fiscal year in which they occur.

The claims originating in fiscal years 1996 and 1997 are closed, with no outstanding balances. Fiscal year 1998 has 3 Medical Only claims pending with \$756 held in reserve to pay the claims. There are three Time Lost claims open for this period, with \$12,800 held in reserve to pay the claims.

Fiscal year 1999 has 97 Medical Only claims pending with \$22,696 held in reserve for payment. Additionally, 40 of the 50 Time Lost claims are still open for this period, with \$111,098 held in reserve to pay the claims.

On the average, there are 7 to 10 hospital employees who are receiving indemnity benefits through workers' compensation and are not able to return to work.

Table 1. lists the totals for each category of claim by fiscal year. The trend in the number of workers' compensation claims is downward, with a decrease of 36 percent from fiscal year 1996 to 1999. The number of workers compensation claims associated with lost time has decreased by 37 percent covering the same period.

The total expenses associated with all workers' compensation claims significantly decreased after 1997. During this period, The Office of Risk Management hired a Claims Manager to monitor and process workers' compensation claims. Additionally during this period, the Office of Risk Management completed training with the different Engineering Departments throughout the University. The training was focused on ergonomics and a safe working environment for all engineering related activities. This training is not provided on a routine basis.

Table 2. lists the average cost for each type of claim by fiscal year. The average cost per claim includes the funds held in reserve for those claims that remain open. The Time Lost claims in 1997 increased by 52 percent as compared to 1996, with a subsequent decrease of 64 percent in 1998.

Table 1. Georgetown University Hospital Workers' Compensation Claims for Fiscal Years 1996 - 1999

Fiscal Year	Medical Only		Time Lost			Total		
	No. Claims	Expenses Paid	No. Claims	Indemnity	Medical Expenses	No. Claims	Medical Expenses	Total Expenses
1999	194	11,275	50	127,261	84,749	244	96,024	223,285
1998	235	20,081	58	67,094	71,403	293	91,484	158,578
1997	277	26,570	68	301,186	192,237	345	218,808	519,994
1996	302	35,849	79	187,649	189,794	381	225,643	413,292

Note: Data obtained from the Office of Risk Management, Georgetown University, as of January 12, 2000.

The average cost of Time Lost claims dramatically increased by 149 percent in 1999 as compared to 1998, despite the decrease in the number of claims. This may be attributed to the severity of the associated injuries.

Five of the diagnosis categories comprise 90 percent of the total expenses associated with the workers' compensation program for all four fiscal years. Excluding the amputation in fiscal year 1996, all of the fiscal years have similar diagnoses, with some variation as to the

actual ranking. The top five diagnosis codes for all four fiscal years are some form of strains, fractures, contusions, lower back strains, and sprains. Predominantly, the majority of the top 5 diagnosis codes are related to musculoskeletal injuries.

Table 2. Georgetown University Hospital Average Cost per Claim - Fiscal Years 1996 - 1999

Fiscal Year	Medical Only (\$)	Time Lost (\$)
1999	172	6,462
1998	89	2,600
1997	96	7,256
1996	119	4,777

Note: Fiscal years 1999 and 1998 include the cash held in reserve of pending claims.

Table 3 lists the top five diagnosis codes for fiscal years 1996 through 1999, with the corresponding cost.

Appendix E lists the costs associated by fiscal year and department for workers' compensation claims. As the Workers' Compensation Program matured over the four-year period, greater detail and specific cost centers within the

hospital were identified and credited for their respective expenses. The departments with the majority of the expenses associated with the workers' compensation claims are engineering related departments and nursing service employees.

Table 3. Georgetown University Hospital Top Five Diagnosis Codes by Fiscal Year.

Fiscal Year 1999		Fiscal Year 1998		Fiscal Year 1997		Fiscal Year 1996	
Code	Expense (\$)	Code	Expense (\$)	Code	Expense (\$)	Code	Expense (\$)
Strain	85	Strain	104	Strain	278	Strain	210
Fracture	54	Herniated Disk	19	Contusion	109	Fracture	47
Contusion	40	Lower Back Strain	13	Inflammation	62	Amputation	32
Lower Back Strain	20	Contusion	5	Sprain	23	Sprain	26
Sprain	5	Fracture	4	Trauma	16	Lower Back Strain	22
Total	\$ 204		\$ 145		\$ 488		\$ 337

Note: Values in \$000

Disability Program. Short Term Disability (STD)

benefits are designed to provide income to an employee during an absence from work because the employee is unable to perform his/her duties of the job due to illness or injury. The illness or injury may not be job related. Otherwise, the Workers' Compensation Program provides indemnity and medical benefits for those injuries and illnesses associated with employment.

The Short Term Disability (STD) Plan at Georgetown University Hospital [nonunion workers] provides a 50-day benefit period with a mandatory elimination period consisting of 15 continuous workdays. The employee uses either paid vacation or sick leave during the elimination period. On the 16th day, they may apply for Short Term Disability.

Short Term Disability Plan benefits are included in the compensation package for Georgetown University Hospital staff employees hired to work at least 30 hours per week and those employees covered by the collective bargaining agreement with Allied International Health. Employees are eligible for coverage on the first day of employment and the cost of the plan is paid for by the Hospital.

The Georgetown University Hospital Long-Term Disability (LTD) plan provides a benefit of 60 percent of the base pay with a maximum of \$15,000 per month. The benefits begin after a three-month waiting period and are coordinated with the short-term disability benefits. A member may collect LTD benefits until they are no longer disabled or for five years, which ever occurs first. Benefits may be extended beyond the five-year period if the employee is unable to engage in any occupation for which they are reasonably trained. The LTD benefits are reduced by any wages, social security, or any disability or early benefit received under the University sponsored retirement plan. Additionally, if the employee participates in another LTD plan, the benefits paid through the LTD plan are reduced by that amount as well.

The LTD Plan is coordinated and administered by UNUM® and funded by employee and hospital contributions. The cost for LTD benefits for the first \$1000 of the monthly base pay is paid for by the hospital. The employee pays \$.50 for each additional \$1000 of the monthly base pay from \$1,000 to \$8,333.33 and \$.55 for each \$100 of monthly base pay from \$8,333.34 to \$25,000. Table 4. is an example of a contribution schedule.

Table 4. Georgetown University Hospital LTD Plan
Contribution Schedule

Monthly Pay (\$)	Annual Pay (\$)	Employee Biweekly Cost (\$)	Employee Monthly Cost (\$)
1,250	15,000	.63	1.25
1,500	18,000	1.25	2.50
2,000	24,000	2.50	5.00
2,500	30,000	3.75	7.50
3,000	36,000	5.00	10.00
4,166	50,000	7.92	15.83
6,250	75,000	13.13	26.25
8,333	100,000	18.33	36.67
16,666	200,000	41.25	82.50

Note: Contribution Schedule provided by Georgetown University Benefits Summary Pamphlet, revised 4/99.

The Georgetown University Hospital Short and Long Term Disability Program is coordinated by the Georgetown University Faculty and Staff Benefits Office and administered by UNUM®, Short Term Disability Carrier. UNUM® was contracted in 1997 to provide disability services. Prior to 1997, the short disability program was self-funded. UNUM® is contracted for the entire university system; however, the database is maintained with separate divisions for the different entities within the university

organization. Georgetown University Hospital comprises two of the divisions within the university plan, Georgetown Hospital and Georgetown Hospital 1199E. The divisions include the hospital staff and District 1195E-DC, Health Care Workers Union, S.E.I.U., respectively. The data available for the analysis of the Disability Program are from March 1, 1998 to March 4, 2000.

Appendix F, Georgetown University Non-Occupational Injury and Illness Benefits, is a flow chart representing the claims process for those qualified staff members seeking short and long-term disability benefits.

Currently, a covered employee contacts the Georgetown University Faculty & Staff Benefit Office to request a Short-Term Disability claim package. The employee is required to complete the employee section and have the supervisor and physician sections completed by the respective member. The Georgetown University Faculty & Benefits Office completes the employer portion of the claim. All sections are forwarded to UNUM® via fax or mail by the member completing the respective section.

UNUM® reviews the claim to ensure eligibility requirements are met. Additionally, a Medical Specialist and Vocational Expert review the claim to determine if the

employee is eligible; additional information may be required.

Georgetown University Hospital had 148 short-term disability claims in the amount of \$687,684 from March 1, 1998 to March 4, 2000. This consists of 35 claims, at a cost of \$90,723, from unionized hospital employees and 114 claims, at a cost of \$596,729, from nonunion hospital employees. Four of the claimants had two claims filed. The remaining claimants only filed one claim. Typically, there are approximately five to seven employees off of work and receiving short-term disability.

Table 5 represents 88 to 89 percent of the top ranking diagnoses by incidence and cost for short-term disability claims of nonunion hospital employees. Pregnancy is 14 percent higher for the Hospital as compared to similar institutions within the UNUM® database. The remaining diagnoses are within 1 - 2 percent of the UNUM® database.

Table 6 represents 88 to 89 percent of the top ranking diagnoses by incidence and cost for short-term disability claims of union hospital employees. The top ranking diagnosis is injury/poisoning accounting for 35.7 percent of the claims with 45.7 percent of the total cost.

The data are not segregated by fiscal year for this comparison, rather they are combined. However, it should be noted the average claim cost is increasing.

The Short and Long-Term Disability Plans are administratively managed with little, if any, medical/case management. This is a consistent finding with the Workers' Compensation Program as well.

Table 5. Top Ranking STD Diagnoses by Incidence and Cost for Nonunion Georgetown University Hospital Employees

Diagnosis	Percentage of Total	
	Incidence	Cost
	(%)	(%)
Pregnancy	43.8	43.0
Injury/Poisoning	14.3	12.6
Tumor	10.5	6.8
Musculo-skeletal/Connective	10.5	13.6
Genitourinary	6.7	5.8
Circulatory	2.9	6.3

Note: Source - UNUM®

It should be noted however, despite the lack of a managed care contract with the delivery of WC Program, the majority of the employees report to Employee Health Services located within the hospital for care and treatment. This is a

positive note and it potentially provides an excellent opportunity to manage the costs associated with WC.

Table 6. Top Ranking STD Diagnoses by Incidence and Cost for Unionized Georgetown University Hospital Employees

Diagnosis	Percentage of Total	Percentage of Total
	Incidence	Cost
	(%)	(%)
Injury/Poisoning	35.7	45.7
Pregnancy	21.4	19.6
Other	10.7	9.4
Musculo-skeletal/Connective	10.7	8.8
Infectious/Parasitic	7.1	7.3

Note: Source - UNUM®

Discussion

The Georgetown University Workers' Compensation Program is similar to the Provider Network Model that was defined and funded for research by RWJF in 1996. The Provider Network Models selected for evaluation by RWJF included provisions for the development of physician networks and the use of a variety of managed care elements to control the costs associated with workers' compensation. Although the District of Columbia provides for freedom of choice for the initial provider, the majority of the employees at Georgetown seek and obtain medical services at Georgetown University Medical Center. This relationship is informal and is not required by contract or benefit provisions. It should be noted however that the result is the same; GUMC physicians, a physician network, see the majority of the employees seeking care under the workers' compensation program.

Additional similarities with the Workers' Compensation Program Model currently in use at Georgetown include a discounted fee structure, case management, and bill review. Georgetown's case management element is included in the contract with Corvel (TPA) however coordination and communication among the different parties is less than optimum. Case management should provide coordination and

communication among the employer, the injured employee, physician, therapists, insurers, lawyers, WC Commissioners and others (Dembe, A. E., Himmelstein, J. S., Stevens, B. A., & Beachler, M. P., 1997, July/August, p. 255).

Georgetown is likely to benefit from a well-coordinated case management program. Emphasis is placed on bill review and the use of a discounted fee structure.

The state-approved managed care model with various mandatory components including utilization review, bill review, and treatment guidelines directed towards workers' compensation health care is unlikely to be implemented in the District of Columbia due to the political environment. The District of Columbia does not prevent individual organizations from conducting utilization review and bill review. Additionally, voluntary treatment guidelines may be implemented as well. The ability to effectively implement these cost control measures is hampered because it is not state mandated. Georgetown University does have provisions for bill review. Utilization review and treatment guidelines are not formalized components of the program. The Employee Health department does provide medical management of hospital employees.

An integrated disability management model facilitates return-to-work efforts, improves productivity, is cost and

personnel efficient and it eliminates redundancies within the workers' compensation, disability, and sick pay programs. This model is referred to as the twenty-four hour model. The twenty-four hour model does however represent an exciting and potentially viable option for Georgetown.

Corvel (TPA) reviews all workers' compensation claims (bills) prior to payment. Georgetown does not have a formalized utilization review structure for workers' compensation claims.

Georgetown University administers the Workers' Compensation and the Short and Long Term Disability Programs. Ultimately, with the pending purchase of Georgetown University Hospital by MedStar, Georgetown University Hospital will be required to develop and coordinate both the workers' compensation program and the disability program for the hospital employees. The existing organizational structure must be modified to support both programs. Although the culture at Georgetown is resistant to change, the acquisition provides the necessary catalyst for change.

Both programs have recorded a reduction in expenses however, recent trends indicate the costs associated with both programs are beginning to rise. This may be due in part to the organizational structure of both programs with

departments supporting the programs located throughout the university complex. The administrative and medical management of employees is hampered due to the complexity of reporting relationships and decentralized management.

The Workers' Compensation Program and the Short and Long-term Disability Benefit Plans are geographically and functionally separated. The separation of the programs and the actual location of the different offices supporting these two programs places a burden on the individual employee to file, coordinate and receive the different benefits associated with occupational and non-occupational injuries and illnesses.

Although the related diagnoses are considerably different for the two programs, a common element is present within both programs. The primary intent of the programs is to facilitate the return of the employee to work and reduce the amount of time the employee is unavailable to work. Neither of the programs aggressively promotes return to work. This may be problematic, considering the diminishing labor pool within the National Capital Region.

Both of the WC and the Benefits Programs have implemented cost reduction strategies to reduce the expenses associated with the programs. The WC Program employed a Claims Manager to administratively manage all

the claims. Initially there was a reduction in expenses due to administrative management of the program. It should be noted however, the cost per claim is rising. The initial savings associated with administrative management by the University have been fully realized and it's likely, without medical management, no additional savings will be gained.

The University contracted UNUM®, Third Party Administrator, to manage the Disability Program in late 1997. Prior to this date the University was self-insured and based on a cost analysis, the University would realize cost savings with UNUM®. There has been an overall reduction in direct expenses; however, the indirect expenses associated with implementation of the program are difficult to measure.

The culture within academic medicine is resistant to change and due to the acquisition discussions with MedStar, significant changes within the Workers' Compensation and Disability Programs could adversely affect the morale of the employees. However, the pending purchase of Georgetown University Hospital by MedStar does provide a unique opportunity to improve the existing programs and incorporate change. The University administers both the Workers' Compensation and Benefits Programs. After the

sale, the hospital will be required to develop processes and procedures to manage these programs. This will provide the opportunity to implement the necessary changes and improve the coordination within both programs.

Recommendations

The recommendations that follow capitalize on existing industry trends with the primary intent to reorganize and implement program modifications to maximize existing capabilities at Georgetown University Hospital. The primary emphasis of these recommendations is to improve the quality of the services provided to the employees and reduce the costs, both direct and indirect, associated with occupational and non-occupational injuries and illnesses. Based on this philosophy, a hybrid model, including program oversight, is presented to facilitate improvement with both programs.

It should be recognized some of the elements of the model would be dictated by the subsequent MedStar acquisition. This should not affect the overall management and program structure, critical elements are required regardless. For the purposes of this model, one may assume MedStar is self-insured for the Workers' Compensation Program and insured for short and long term disability benefits. This is consistent with the current program structure offered and managed by Georgetown University.

The hybrid model suggested relies heavily on the Workers' Compensation Program currently in use at Johns Hopkins. As is Georgetown, Johns Hopkins is located within

a state that allows individual employee freedom of choice as to their initial provider. Despite that freedom and constraint, Johns Hopkins has implemented a successful model capitalizing on case management and managed care principles. Appendix G is the recommended Workers' Compensation & Non-occupational Injury and Illness Management System. The recommended model incorporates The Employee Health Services (EHS) as the focal point for the initial screening and the working level administrative support.

The employee who has sustained an injury or illness will proceed to or contact Employee Health Services. This should include occupational and non-occupational injuries and illnesses. This will ensure employees are able to return to work without placing themselves or the patients at risk. EHS will ensure the employee is administratively entered into the appropriate program to support the injured/ill employee. A determination of whether the injury or illness is occupationally related should be determined early to ensure the appropriate administrative requirements and financial support is maintained to support the employee. The primary emphasis is on medical management and return-to-work. The existing program supported by the University is focused on claims management. The theory is

to reduce the direct and indirect costs through aggressive case management and a successful return-to-work program.

Employees that present to Employee Health Services are appropriately evaluated and financially supported by the benefits plan or workers' compensation. Those employees that sustain work related injuries/illnesses are medically evaluated and the required forms from The District of Columbia Workers' Compensation Program are completed and filed. The administrative claim forms required by the DC Workers' Compensation Commission are completed with the assistance of the employee and filed with the district office.

In addition to completing the required workers' compensation claim forms, EHS enters the required data into a claims database program. The database will provide for overall program management. A copy of RiskMaster (risk management software) should be purchased and provided to EHS. This software includes a model to monitor work-related injuries and illnesses. This software should be installed on an existing computer within the confines of EHS. Although MedStar may mandate alternative software support, the actual software used will not affect the implementation of the program. EHS will input the initial data and information to support the workers' compensation program

using existing administrative support staff. Based on the relative low number of active claims, this should not overwhelm the existing staff in EHS.

The most critical component of the hybrid model includes case management. The occupational health nurse should provide case management for all employees sustaining occupational and non-occupational injuries and illnesses. EHS will coordinate the care and services provided by the Faculty Practice Group, Physical Medicine & Rehabilitation, and any other specialty service required. This component will capitalize on the existing physician network and the discounted fee structure associated with the current system in use by the University.

Claims management can be accomplished by using a TPA: UNUM® for benefit claims and Corvel® for workers' compensation claims. The claim could be forwarded by EHS to the appropriate TPA for utilization management. This will require a contract to be implemented to provide these services to the hospital. An alternative recommendation would be to purchase claims management services through the University Program. Regardless of the methodology used, A TPA is used to review the claims. The Hospital could eliminate a step in the process by forwarding the claim directly to the TPA.

A sub-committee of the Environmental Health & Safety Committee should provide program oversight and executive level support. Membership should include the Senior Operating Officer-Facilities, Risk Management, the Director, Employee Health Services, the Director, Human Resources, the Director, Office of Environmental Health & Safety, a Physician, and legal council. The sub-committee should monitor the return-to-work program and evaluate the overall performance of the program. Without executive level support, it is unlikely the program will attain maximum efficiency and benefits. The sub-committee should receive a quarterly executive summary of the program to monitor overall performance and trends. As the program matures, targeted training and safety measures can be implemented to reduce associated direct and indirect costs.

The Human Resource Department should be responsible for the presentation and selection of benefits for the new employee. This will require a position to be created and staffed within HR.

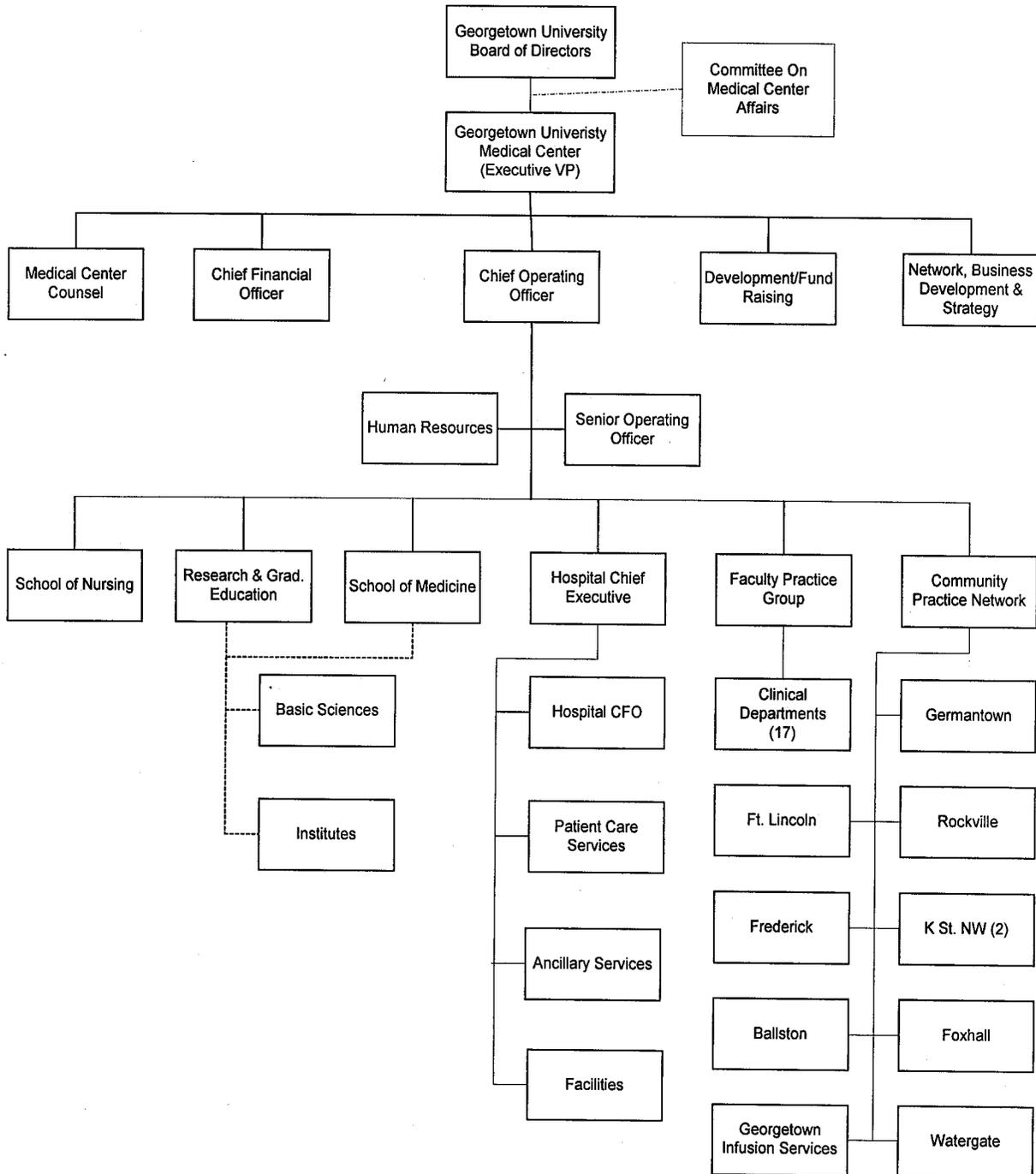
The final recommendation involves improvement of communication. Active participation by all managers within the organization is essential to ensure the success of the program. An employee who sustains an injury or illness is much more likely to return-to-work sooner with a department

that has expressed concern and an active interest in their well being. Supervisor's must take the initiative and contact the injured/ill employee as quickly as possible. This does not require a tremendous amount of effort or time; however, it yields tremendous dividends.

Appendix H includes an outline of the implementation plan to support the required program changes as a result of the purchase.

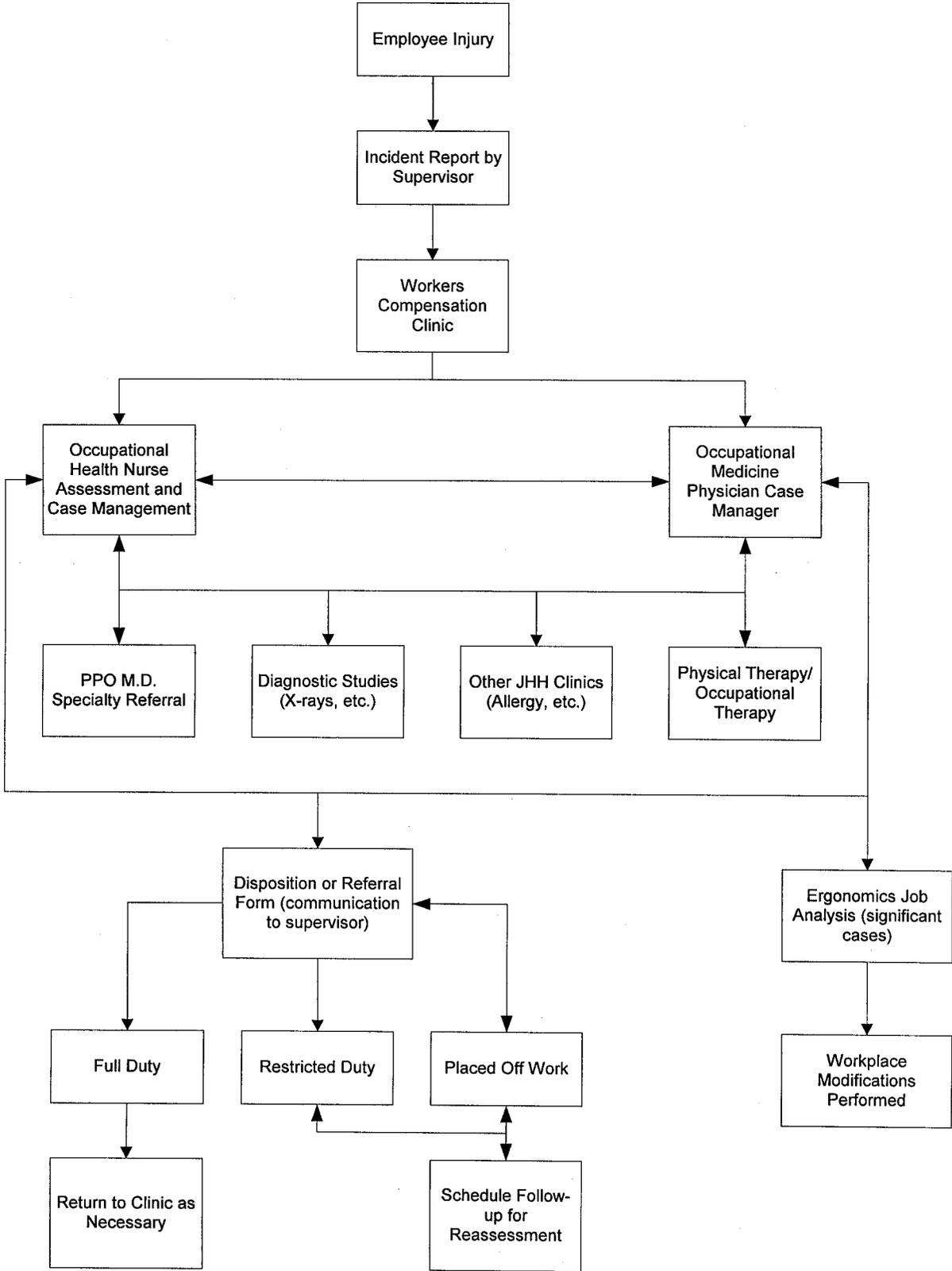
Appendix A

Georgetown University Medical Center Organizational Chart



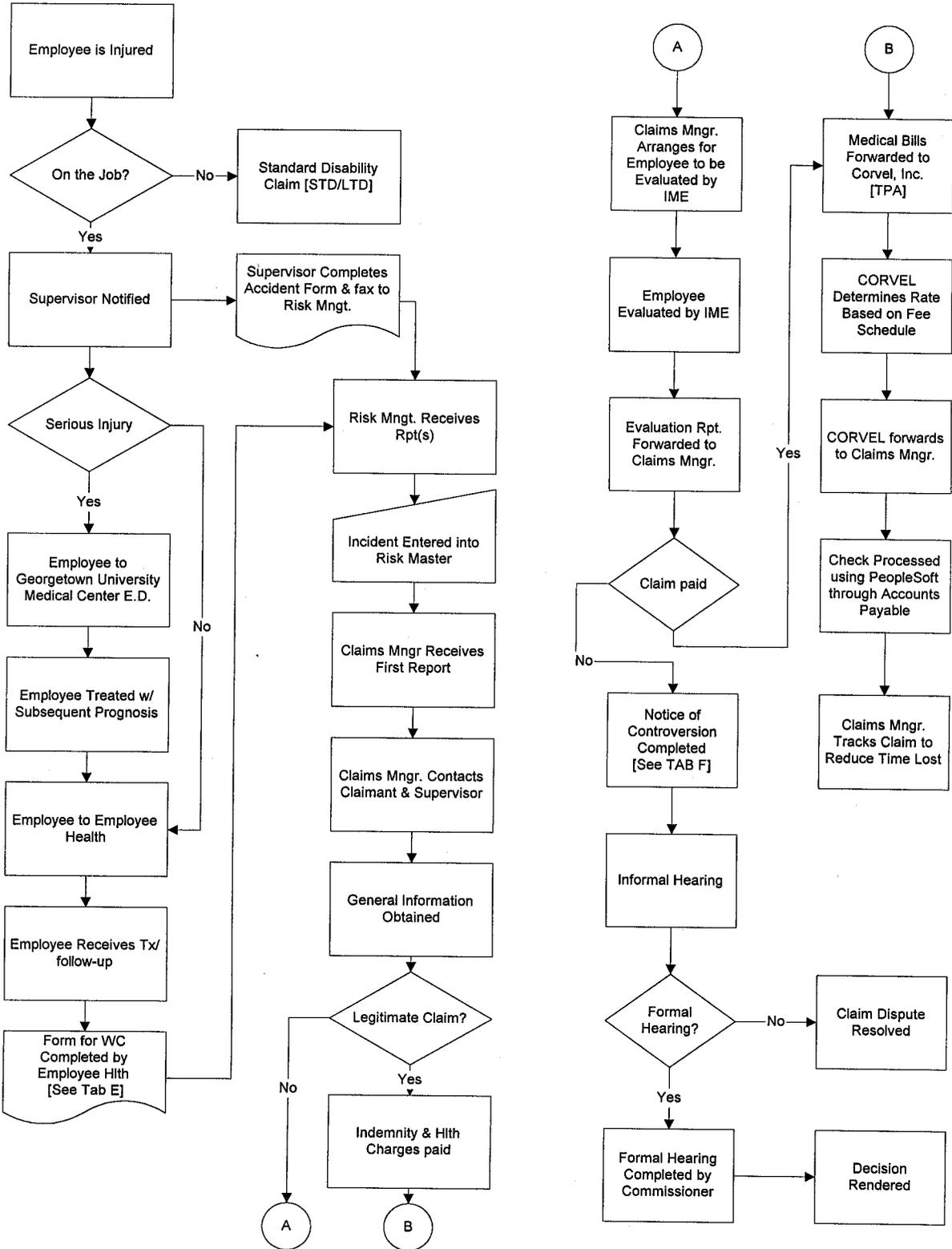
Appendix B

Johns Hopkins Workers' Compensation Management System



Appendix C

Occupational Injury Claim Process



Appendix D-1

Georgetown University Hospital WC FY 99

Diagnosis	Medical Only		Time Lost		Totals		
	No. Claims	Expenses Paid	No. Claims	Indemnity	No. Claims	Medical Expenses	Total
Strain	11	1,132.17	15	46,503.40	26	38,025.68	84,529.08
Fracture	1	21.00	6	39,475.23	7	14,742.82	54,218.05
Contusion	6	306.94	6	19,155.49	12	20,891.69	40,047.18
Lower Back Strain	2		13	14,069.52	15	6,236.65	20,306.17
Sprain	6	1,273.12	2	2,616.71	8	2,501.09	5,117.80
Needle Stick	95	4,154.28			95	4,154.28	4,154.28
Trauma	8	378.38	2	2,622.23	10	1,099.00	3,721.23
Splash/fluid	14	403.12	1	512.96	15	2,007.19	2,520.15
Herniated Disc.			1	1,749.60	1	642.75	2,392.35
Laceration	7	643.51	1	290.48	8	1,071.95	1,362.43
None			1		1	1,150.26	1,150.26
Blood Splash	16	1,086.91			16	1,086.91	1,086.91
Burns	1	120.00	1	265.20	2	658.54	923.74
Puncture/other	10	773.12			10	773.12	773.12
Foreign Body	5	420.19			5	420.19	420.19
Abrasion	4	200.25			4	200.25	200.25
Bruise	1	188.38			1	188.38	188.38
Rupture	1	173.25			1	173.25	173.25
All Other	1		1		2	0.00	0.00
Contagious Disease	1				1	0.00	0.00
Dermatitis	1				1	0.00	0.00
Do not use	1				1	0.00	0.00
Exposure to Disease	1				1	0.00	0.00
Repetitive Stress	1				1	0.00	0.00
Amputation					0	0.00	0.00
Concussion					0	0.00	0.00
Dust Disease					0	0.00	0.00
Infection					0	0.00	0.00
Inflammation					0	0.00	0.00
Mental Disorder					0	0.00	0.00
Poisoning/Metal					0	0.00	0.00
Respiratory					0	0.00	0.00
Vision Loss					0	0.00	0.00
Total	194	11,274.62	50	127,260.82	244	96,024.00	223,284.82

Appendix D-2

Georgetown University Hospital WC FY 98

Diagnosis	Medical Only		Time Lost		Totals		
	No. Claims	Expenses Paid	No. Claims	Indemnity	No. Claims	Medical Expenses	Total
Strain	29	7,584.49	26	54,715.22	55	48,892.83	103,608.05
Herniated Disc.			1	3,181.38	1	15,426.82	18,608.20
Lower Back Strain	6	29.45	9	6,262.68	15	6,284.03	12,546.71
Contusion	15	1,537.49	8	964.82	23	3,927.97	4,892.79
Fracture	1	243.75	3		4	3,848.22	3,848.22
Trauma	3	17.25	4	1,851.93	7	1,075.87	2,927.80
Needle Stick	92	2,517.68			92	2,517.68	2,517.68
Splash/fluid	15	1,872.00			15	1,872.00	1,872.00
Foreign Body	4	944.04	3		7	1,515.73	1,515.73
Blood Splash	18	1,116.81		571.69	18	1,116.81	1,116.81
Laceration	12	816.60	2		14	1,038.23	1,038.23
Abrasion	7	818.43			7	818.43	818.43
Sprain	5	314.96	1		6	676.21	676.21
Burns	5	290.55	1	117.81	6	495.48	613.29
Puncture/other	8	613.13			8	613.13	613.13
Repetitive Stress	1	500.00			1	500.00	500.00
Respiratory	1	372.64			1	372.64	372.64
Bruise	1	201.94			1	201.94	201.94
Do not use	7	144.75			7	144.75	144.75
Dermatitis	2	135.00			2	135.00	135.00
Contagious Disease	1	6.53			1	6.53	6.53
Infection	1	3.94			1	3.94	3.94
Amputation					0	0.00	0.00
Concussion					0	0.00	0.00
Dust Disease					0	0.00	0.00
Exposure to Disease					0	0.00	0.00
Inflammation					0	0.00	0.00
Mental Disorder					0	0.00	0.00
Poisoning/Metal	1				1	0.00	0.00
Vision Loss					0	0.00	0.00
Total	235	20,081.43	58	67,093.84	293	91,484.24	158,578.08

Appendix D-3

Georgetown University Hospital WC FY 97

Diagnosis	Medical Only		Time Lost		Totals		
	No. Claims	Expenses Paid	No. Claims	Indemnity	No. Claims	Medical Expenses	Total
Strain	43	3,807.88	26	159,578.52	69	113,892.44	277,278.84
Contusion	14	3,661.50	7	62,906.02	21	42,536.59	109,104.11
Inflammation	2		4	48,583.76	6	13,364.30	61,948.06
Sprain	4	620.25	5	12,929.00	9	9,949.61	23,498.86
Trauma	7	2,429.65	7	9,558.16	14	4,394.56	16,382.37
Needle Stick	104	7,962.14			104	7,962.14	7,962.14
Fracture			1	2,978.82	1	2,245.46	5,224.28
Dislocation			1	1,001.88	1	2,755.04	3,756.92
Lower Back Strain	6	113.31	8	1,165.78	14	1,685.49	2,964.58
Burns	3	140.00	2	1,649.00	5	59.10	1,848.10
Laceration	18	1,558.78	1		19	276.79	1,835.57
Splashfluid	21	1,373.57	2	38.00	23	403.50	1,815.07
Blood Splash	19	1,520.36			19	1,520.36	1,520.36
Foreign Body	5	1,108.54			5	1,108.54	1,108.54
Bruise	2	114.75	1	516.72	3	174.00	805.47
Repetitive Stress	6	474.38		280.45	6	474.38	754.83
Abrasion	9	738.59			9	738.59	738.59
Exposure to Disease	2	484.58	1		3	196.09	680.67
Puncture/other	6	103.31	1		7	221.62	324.93
Respiratory	3	211.64			3	211.64	211.64
Other Cumulative Injury	1	88.50			1	88.50	88.50
Crushing			1		1	82.61	82.61
Dermatitis	1	58.65			1	58.65	58.65
Amputation					0	0.00	0.00
Concussion					0	0.00	0.00
Contagious Disease					0	0.00	0.00
Do not use					0	0.00	0.00
Dust Disease					0	0.00	0.00
Hernia					1	0.00	0.00
Infection					0	0.00	0.00
Poisoning/Metal					0	0.00	0.00
Vision Loss					0	0.00	0.00
Total	277	26,570.38	68	301,186.11	345	218,807.58	519,993.69

Appendix D-4

Georgetown University Hospital WC FY 96

Diagnosis	Medical Only		Time Lost		Totals		
	No. Claims	Expenses Paid	No. Claims	Indemnity	No. Claims	Medical Expenses	Total
Strain	25.00	4,549.11	29.00	97,104.03	54.00	112,775.85	209,879.88
Fracture			4.00	29,649.92	4.00	16,914.80	46,564.72
Amputation	0.00	0.00	1.00	19,914.40	1.00	11,444.00	31,358.40
Sprain	6.00	1,712.06	5.00	6,488.89	11.00	19,845.23	26,334.12
Lower Back Strain	3.00	1,217.91	8.00	10,212.50	11.00	12,008.81	22,221.31
Contusion	8.00	5,344.31	6.00	8,875.14	14.00	10,996.23	19,871.37
Laceration	33.00	7,388.84	3.00	3,164.66	36.00	10,620.15	13,784.81
Trauma	7.00	877.64	8.00	4,203.68	15.00	8,290.06	12,493.74
Inflammation	3.00	3,871.96	1.00	1,738.94	4.00	4,985.96	6,724.90
Bruise			1.00	3,313.53	1.00	2,738.67	6,052.20
Respiratory	3.00	785.32	2.00	2,626.71	5.00	1,209.96	3,836.67
Needle Stick	118.00	1,849.35	1.00	0.00	119.00	3,829.53	3,829.53
Splashfluid	29.00	3,485.77			29.00	3,485.77	3,485.77
Burns	5.00	1,755.49			5.00	1,755.49	1,755.49
Repetitive Stress			1.00	0.00	1.00	1,206.40	1,206.40
Abrasion	3.00	624.50	2.00	0.00	5.00	1,007.95	1,007.95
Exposure to Disease	9.00	957.32	1.00	0.00	10.00	957.32	957.32
Puncture/other	16.00	546.91			16.00	546.91	546.91
Contagious Disease			2.00	356.22	2.00	0.00	356.22
Do not use	3.00	166.50	3.00	0.00	6.00	307.69	307.69
Foreign Body	2.00	280.00			2.00	280.00	280.00
Dermatitis	3.00	229.27			3.00	229.27	229.27
Dust Disease	1.00	206.96			1.00	206.96	206.96
Blood Splash	22.00	0.00			22.00	0.00	0.00
Concussion	1.00	0.00			1.00	0.00	0.00
Infection	1.00	0.00			1.00	0.00	0.00
Mental Disorder			1.00	0.00	1.00	0.00	0.00
Poisoning/Chemical	1.00	0.00			1.00	0.00	0.00
Vision Loss					0.00	0.00	0.00
Total	302.00	35,849.22	79.00	187,648.62	381.00	225,643.01	413,291.63

Appendix E-1

Georgetown University Hospital FY 99 WC by Department

Department	Indemnity	Medical Expense	Total
Nursing Service Office	18,361.48	18,388.64	36,750.12
OR - General	25,984.20	7,463.14	33,447.34
Medical Records	25,753.35	6,496.12	32,249.47
Environmental Services	15,025.08	10,758.41	25,783.49
C6-1 General Surgery	4,670.25	18,360.62	23,030.87
7 East	9,564.92	4,047.28	13,612.20
Dietary - Hospital	4,007.70	5,721.65	9,729.35
CARD-Echocardiology	3,455.70	4,343.02	7,798.72
Facilities Management	3,507.97	2,987.01	6,494.98
6 main - Ortho	1,568.90	1,914.09	3,482.99
Hospital Total	3,325.57	4.09	3,329.66
Pediatrics	2,576.70	461.44	3,038.14
Residents & Interns		2,962.61	2,962.61
RAD-Angiography Lab-Tech	1,752.00	657.14	2,409.14
POD 4-2/MSCU/CSCU	2,105.73	286.06	2,391.79
2 north -OB	1,033.00	1,225.33	2,258.33
Cardiac Surgery	1,742.91	1.83	1,744.74
International Services	911.24	544.59	1,455.83
Lab-Collection/Accession		1,150.26	1,150.26
PM&R	257.28	813.32	1,070.60
Nursery - Critical Care	45.53	875.03	920.56
LAB-Blood Bank	265.20	538.54	803.74
Nursing Floor Floates		694.39	694.39
Endoscopy Suite - 2N		621.77	621.77
Bone Marrow Transplant		566.82	566.82
Critical Care Monitoring	194.64	354.23	548.87
Piccard Drive	548.67		548.67
Pathology		501.94	501.94
7 West		481.31	481.31
General Surgery	465.84	0.00	465.84
Emergency Room - Clerical	91.12	349.50	440.62
OR-Endourology		365.44	365.44
BLES 7 / Medical		271.05	271.05
Engineering		261.19	261.19
Nursery - Regular		188.65	188.65
Nursing - Delivery Room		184.88	184.88
POD 4-1/MED		181.31	181.31
NSG Transportation		163.50	163.50
RAD - Nursing		140.81	140.81
Chemotherapy		124.88	124.88
OR Anesthesia Tech Labor		112.50	112.50
OB & GYN		94.50	94.50
Parking Facilities		83.25	83.25

Department	Indemnity	Medical Expense	Total
RAD - Film Librarian		62.25	62.25
Anesthesia Total		51.75	51.75
Security Service	45.84		45.84
Case Management		21.00	21.00
RAD-Admin		7.43	7.43
Respiratory Therapy		1.43	1.43
Anesthesia NIH			0.00
Antenatal Testing			0.00
BLES 3/GYN			0.00
BLES 4 / Medical			0.00
Critical Care Cluster			0.00
Human Resources			0.00
LAB-Chemistry			0.00
Lab-Microbiology			0.00
Lab-outside Services			0.00
Lombardi Clinci			0.00
Medicine, Infectious Diseases			0.00
Medicine/Oncology Cluster			0.00
MM-Central Stores			0.00
MM- Fabric Care Center			0.00
NSG OCC POD 5-2 PICU			0.00
Nursery - Milk Bank			0.00
Nursing - Admin			0.00
Nursing - Emergency Room			0.00
Nursing - Observation Unit			0.00
Nursing - 5 West Mental Hlth			0.00
Nursing - P/D Pool			0.00
OR - Material Mgmt.			0.00
OR - Same Day Surgery			0.00
OR - Same Day Surgery Preop			0.00
OR - Same Day Postop			0.00
Otolaryngology			0.00
Pastoral Care			0.00
Patient Financial Services			0.00
Pharmacology			0.00
Pharmacy			0.00
POD 5-3/PED			0.00
POD 6-1/SSCU			0.00
POD 6-3/Surgical			0.00
Purchasing			0.00
Radiology			0.00
RAD - MRI Center			0.00
RAD-Nursing			0.00
Shady Grove			0.00
Transportation Center			0.00
UBS Hospital Based SVCS			0.00
Psy Partial Hosp. Program			
RAD - Ultrasound Tech		138.00	
Surgery - Neurosurgery			
Volunteer Services			
	\$ 127,260.82	\$ 96,024.00	\$ 223,284.82

Appendix E-2

Georgetown University Hospital FY 98 WC by Department

Department	Indemnity	Medical Expense	Total
<i>Engineering</i>	37,969.03	19,219.53	57,188.56
<i>Nursing - 5 West Mental Hlth</i>	3,181.38	15,426.82	18,608.20
<i>Respiratory Therapy</i>	1,764.62	9,437.84	11,202.46
<i>BLES 7 / Medical</i>	4,822.69	6,093.16	10,915.85
<i>Environmental Services</i>	3,177.93	5,991.60	9,169.53
<i>Nursing Service Office</i>	3,425.44	1,371.06	4,796.50
<i>Bone Marrow Transplant</i>	1,846.04	2,140.62	3,986.66
<i>Lab-outside Services</i>	328.12	3,501.39	3,829.51
<i>MM-Central Stores</i>	2,203.23	1,412.25	3,615.48
<i>Residents & Interns</i>		3,580.02	3,580.02
<i>Patient Financial Services</i>	1,019.28	2,547.19	3,566.47
<i>POD 4-2/MSCU/CSCU</i>	1,933.00	1,104.81	3,037.81
<i>RAD-Angiography Lab-Tech</i>	1,851.93	791.25	2,643.18
<i>OR - General</i>		2,583.68	2,583.68
<i>Nursing - Delivery Room</i>	1,428.69	800.63	2,229.32
<i>Nursing Floor Floates</i>	413.04	1,742.77	2,155.81
<i>Dietary - Hospital</i>	1,391.84	755.05	2,146.89
<i>General Surgery</i>		1,549.14	1,549.14
<i>Medical Records</i>		1,525.54	1,525.54
<i>RAD-Diagnostic-technical</i>		1,049.62	1,049.62
<i>Transportation Center</i>	41.36	743.08	784.44
<i>Pathology</i>		781.39	781.39
<i>Nursery - Critical Care</i>		714.71	714.71
<i>OR - Same Day Postop</i>	82.92	586.82	669.74
<i>Lab-Collection/Accession</i>		576.83	576.83
<i>Dietary-Marriot</i>		546.01	546.01
<i>RAD-CAT SCAN-ULTRA</i>		501.52	501.52
<i>PM&R</i>	112.92	307.36	420.28
<i>CARD-Clinical</i>		418.76	418.76
<i>International Services</i>		408.38	408.38
<i>MM-Materials Mgmt. Center</i>		312.19	312.19
<i>7 East</i>		252.39	252.39
<i>Facilities Management</i>		232.16	232.16
<i>OR Anesthesia Tech Labor</i>		201.94	201.94
<i>Anesthesia Total</i>		186.00	186.00
<i>RAD-Admin</i>		179.82	179.82
<i>Antenatal Testing</i>		175.88	175.88
<i>BLES 3/GYN</i>		170.81	170.81
<i>NSG OCC POD 5-2 PICU</i>		165.15	165.15
<i>POD 4-1/MED</i>		162.75	162.75
<i>Purchasing</i>		135.00	135.00
<i>Budget & Reimbursement</i>		130.50	130.50
<i>POD 5-3/PED</i>		124.87	124.87
<i>CARD-HEART CATH LAB</i>		121.96	121.96

Appendix E-3

Georgetown University Hospital FY 97 WC Expenses by Department

Department	Indemnity	Medical Expense	Total
<i>Engineering</i>	92,390.91	64,037.40	156,428.31
<i>Employee Health Service</i>	58,807.03	29,555.04	88,362.07
<i>POD 4-2/MSCU/CSCU</i>	61,578.37	23,229.66	84,808.03
<i>OR Anesthesia Tech Labor</i>	35,381.80	25,639.57	61,021.37
<i>Security Service</i>	8,292.11	16,129.36	24,421.47
<i>RAD-Admin</i>	6,990.74	13,278.28	20,269.02
<i>POD 6-3/Surgical</i>	10,264.92	5,455.83	15,720.75
<i>Environmental Services</i>	5,284.35	8,323.24	13,607.59
<i>Dietary-Marriot</i>	3,144.25	5,673.97	8,818.22
NSG OCC POD 5-2 PICU	6,284.38	598.19	6,882.57
Residents & Interns		6,860.05	6,860.05
Pathology	2,978.82	2,312.21	5,291.03
Facilities Management	1,477.01	2,650.70	4,127.71
Cadiac Surgery	3,273.86	835.93	4,109.79
OR - Same Day Postop	1,165.78	1,934.98	3,100.76
6 main - Ortho	2,015.44	819.13	2,834.57
Transportation Center	1,493.61	905.81	2,399.42
2 north -OB		962.08	962.08
Respiratory Therapy		904.66	904.66
Lab-Outside Services		876.60	876.60
OR - General	324.60	317.03	641.63
Pastoral Care		620.40	620.40
Prostratron	38.13	525.91	564.04
Nursing Floor Floates		524.94	524.94
Microbiology Medicine		449.12	449.12
Pediatrics		424.63	424.63
PM&R		386.77	386.77
Nursing - P/D Pool		383.19	383.19
BLES 3/GYN		381.51	381.51
Nursery - Critical Care		331.76	331.76
POD 6-1/SSCU		328.00	328.00
Nursing - Emergency Room		323.81	323.81
Anesthesia Total		297.56	297.56
Trauma		230.33	230.33
RAD-MRI Center		223.69	223.69
7 West		160.50	160.50
CARD Administration		160.50	160.50
Radiation Therapy		147.00	147.00
Lombardi Clinic		141.19	141.19
MM Central Sterile		125.25	125.25
Nursing - Observation Unit		124.97	124.97
General Surgery		122.59	122.59
Office of Administrator		122.44	122.44
Endoscopy Suite - 2N		120.56	120.56
BLES 7 / Medical		104.81	104.81
RAD-Nuclear Medicine		103.31	103.31
POD 5-3/PED		102.00	102.00

Department	Indemnity	Medical Expense	Total
C5-1-PEDS		80.25	80.25
Nursery - Milk Bank		80.25	80.25
Nursing - Delivery Room		80.25	80.25
Pharmacology		80.25	80.25
Lombardi Cancer Center		63.19	63.19
POD 4-1/MED		57.00	57.00
Pharmacy		44.73	44.73
Human Resources		24.80	24.80
RAD-CAT SCAN-ULTRA		16.95	16.95
Social Services		13.45	13.45
Adult Dialysis			0.00
Anesthesia NIH			0.00
BLES 4 / Medical			0.00
EVP Medical Center			0.00
Medical Center Finance			0.00
Medicine, Oncology			0.00
Neurodiagnostics Admin			0.00
Nursery - Regular			0.00
Nursing - Admin			0.00
Nursing - 5 West Mental Hlth			0.00
OR - Same Day Surgery			0.00
payroll Office			0.00
	\$ 301,186.11	\$ 218,807.58	\$ 519,993.69

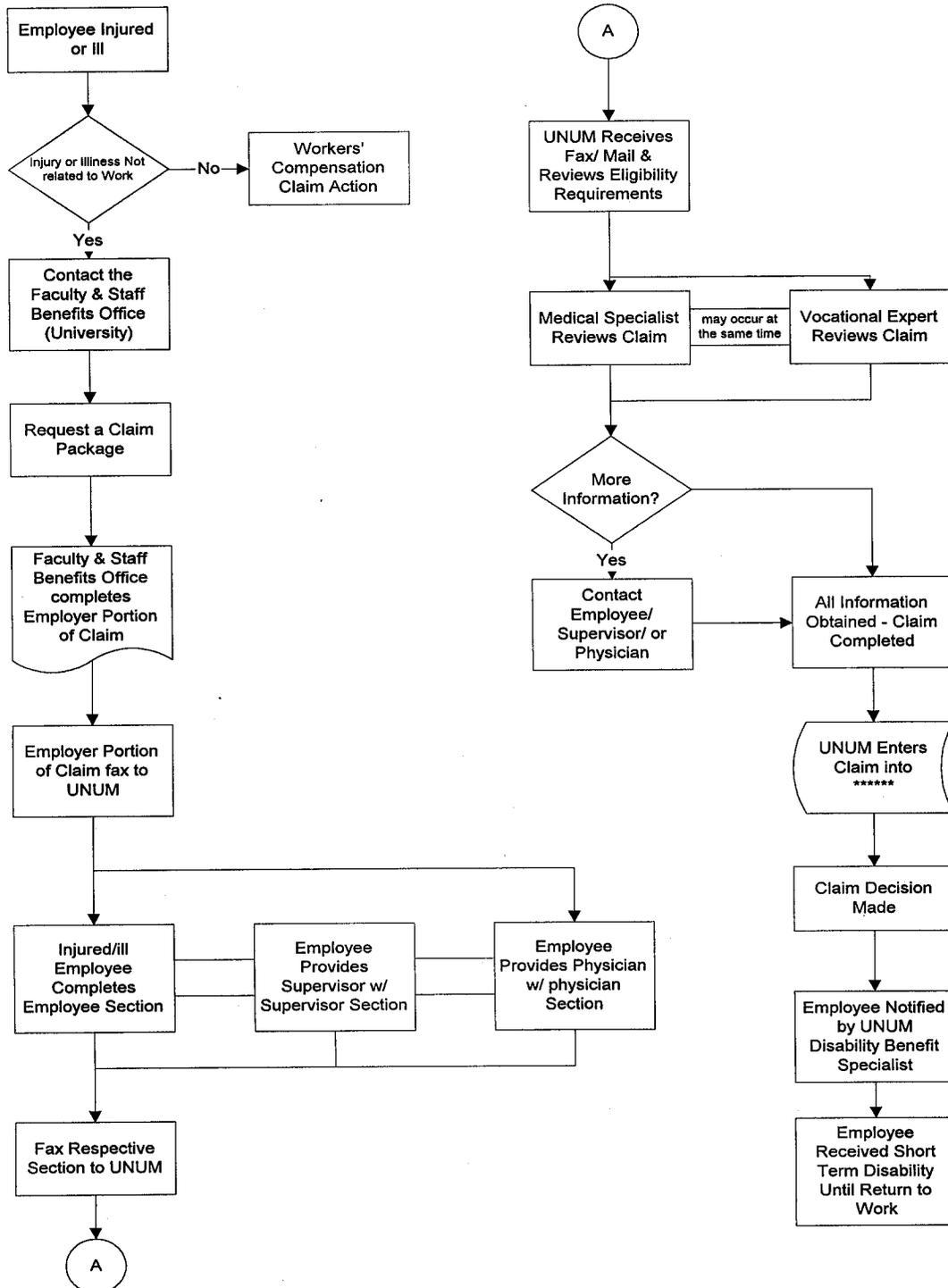
Appendix E-4

Georgetown University Hospital FY 96 WC Expenses by Department

Department	Indemnity	Medical Expense	Total
<i>Nursing Service Office</i>	52,004.07	45,971.04	97,975.11
<i>Facilities Management</i>	34,916.80	38,307.65	73,224.45
<i>Materials Management</i>	14,107.09	46,593.54	60,700.63
<i>Engineering</i>	35,774.92	22,858.74	58,633.66
<i>RAD-Administration</i>	30,709.71	23,634.79	54,344.50
<i>RAD_Nuclear Medicine-Tech</i>	4,339.40	7,728.93	12,068.33
<i>Human Resources</i>	3,327.24	7,315.27	10,642.51
<i>Environmental Services</i>	4,130.24	5,372.78	9,503.02
OR-Same Day Surgery	2,969.75	3,560.56	6,530.31
Admitting & Information	3,313.53	2,738.67	6,052.20
Dietary-Marriot	1,333.35	3,441.13	4,774.48
Residents & Interns		4,546.80	4,546.80
Nursing Emergency Room		3,942.29	3,942.29
Pastoral Care		1,466.40	1,466.40
Security Service	67.42	1,146.94	1,214.36
Card Administration		1,206.40	1,206.40
Radiation Therapy		909.82	909.82
OR- Anesthesia Tech Labor		796.27	796.27
Pharmacy		710.20	710.20
Neurodiagnostics		695.63	695.63
Pathology		617.37	617.37
RAD-MRI Center		393.66	393.66
OR-General		368.82	368.82
Anesthesia	356.22		356.22
Endoscopy Suite-2West		264.34	264.34
Trauma		218.81	218.81
Parking Facilities		189.56	189.56
Respiratory Therapy		185.13	185.13
Non-reimbursable	165.30		165.30
Nursing- P/D Pool		152.81	152.81
Clinical Resource Mgmt	58.98	68.44	127.42
Anesthesia NIH	74.60	31.50	106.10
Employee Health Service		90.00	90.00
OR-Sterile Processing		59.82	59.82
Clinical Engineer		59.00	59.00
Accounting			0.00
Adult Dialysis Unit			0.00
Bone marrow Acquisition			0.00
Emergency Room-Clerical			0.00
IVP Medical Center			0.00
Infection Control			0.00
Lab-Microbiology			0.00
Lab-Outside Services			0.00
Medicine General			0.00
Orthopaedics			0.00
Social Services/Discharges			0
TOTAL	\$ 187,648.62	225643.11	\$ 413,291.73

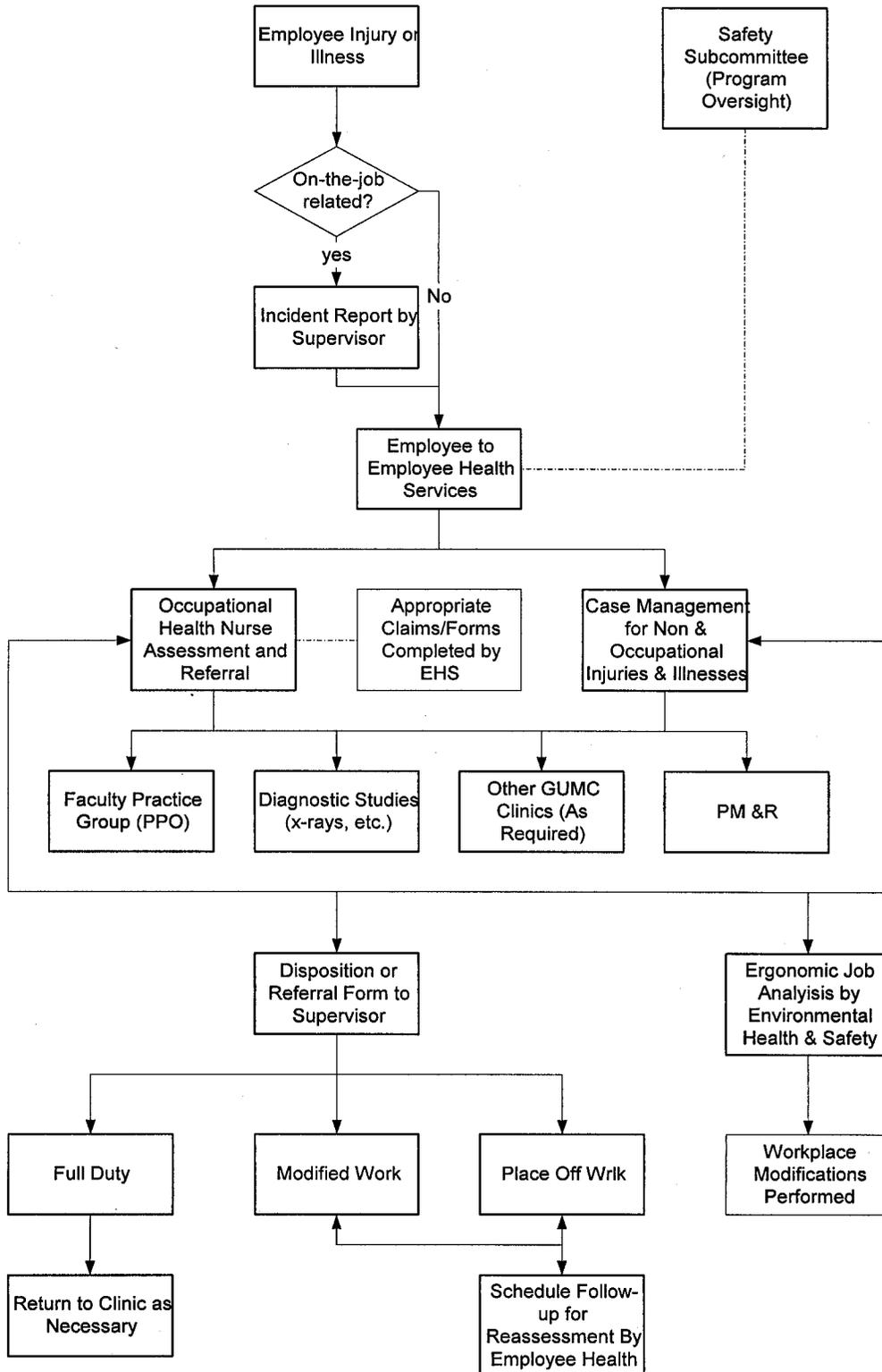
Appendix F

Georgetown University Non-occupational Injury & Illness Benefits



Appendix G

Workers' Compensation & Non-occupational Injury/Illness Management System



Appendix H

Program Implementation Plan

Policy & Procedures

- Contact MedStar Representatives Responsible for WC & Benefits and Obtain MedStar Policies and Procedures [MedStar may be using TPA for claims management]
- Develop Organizational Structure for Program Support
- Develop Georgetown University Hospital Policy for Workers' Compensation and Benefits Program
- Develop Return-to-Work Policy
- Develop Safety Sub-committee charter
- Submit Policies to Executive Board for Approval

Human Resources

- Develop Job Description for Benefits Coordinator [Position located in HR]
- Fill Benefits Coordinator Position
- Provide Training for Benefits Coordinator
- Develop Benefits Brief

Equipment and Infrastructure

- Obtain Necessary Hardware and Software to Support Program Databases
- Install Hardware and Software

Training and Education

- Provide Training for Employee Health Services
 - Review of D.C. Workers' Compensation Program - Claims Process [University Risk Management - Claims Manager]
 - Software Training

Enterprise-wide Communication

- Develop Brief for Clinical & Administrative Managers Regarding Program
- Provide Brief
- Complete Monday Memo Information to Announce Program

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REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0188), Washington, DC 20503.

1. AGENCY USE ONLY <i>(Leave blank)</i>	2. REPORT DATE June 2000	3. REPORT TYPE AND DATES COVERED Final Report (7-99 to 7-00)	
4. TITLE AND SUBTITLE Short and Long-Term Disability and Workers' Compensation Health Care Programs: Management Project at Georgetown University Hospital		5. FUNDING NUMBERS	
6. AUTHOR(S) LCDR (SEL) Thomas Whippen, MSC, USN		8. PERFORMING ORGANIZATION REPORT NUMBER HCA 34-00	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Georgetown University Hospital 3800 Reservoir Rd, NW Washington, DC 20007		9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES) US Army Medical Department Center and School BLdg 2841, MCCS-HRA US Army-Baylor Program in HCA 3151 Scott Rd Suite 1412 Fort Sam Houston, Texas 78234-6135	
10. SPONSORING / MONITORING AGENCY REPORT NUMBER		11. SUPPLEMENTARY NOTES	
12a. DISTRIBUTION / AVAILABILITY STATEMENT A- Approved for Public Release, Distribution is Unlimited		12b. DISTRIBUTION CODE	
<p>13. ABSTRACT <i>(Maximum 200 words)</i></p> <p>The financial challenges associated with the managed care environment in the health care industry have resulted in significant emphasis on cost reduction and improvement in business operations and strategies. Recent acquisition discussions between Georgetown University medical Center and MedStar provide an opportunity to reengineer the Workers' Compensation and Short and Long-Term Disability Programs. Reengineering efforts should be focused on improving services to the employees and reducing the direct and indirect costs associated with these programs.</p> <p>The literature and existing studies support the instruction of a managed care model focused on case management and medical management to reduce direct and indirect costs. The Workers' Compensation and Disability Programs can be organizationally consolidated with the Employee Health Services providing medical management.</p>			
14. SUBJECT TERMS Medical Services, Health care reform, Worker' Compensation, Short and Long-Term Disability		15. NUMBER OF PAGES 78	
17. SECURITY CLASSIFICATION OF REPORT NA		16. PRICE CODE	
18. SECURITY CLASSIFICATION OF THIS PAGE NA	19. SECURITY CLASSIFICATION OF ABSTRACT NA	20. LIMITATION OF ABSTRACT UL	