University of Washington
School of Public Health
Department of Environmental and Occupational Health Sciences
Occupational Epidemiology and Health Outcomes Program

Master's Level Therapists (MLT) Pilot

Deliverable 3

FINAL REPORT

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Executive Summary

MLT Pilot History Summary

Stakeholders requested the Department of Labor & Industries (L&I) change its rules and policy (e.g., WAC 296-21-2702) to allow master's level therapists to treat workers for accepted conditions within their scope of practice. This led to the ongoing Master's Level Therapists (MLT) Pilot which started in January 2020. Only MLTs who apply to the pilot are allowed to treat workers during the 4-year pilot while L&I develops permanent rules. Final rule language, medical coverage decisions and/or payment policy will be informed by pilot results.[1]

The Occupational Epidemiology and Health Outcomes Program at the University of Washington (UW) was asked to develop survey questions to evaluate the MLT Pilot's following objectives:

- Access to care
- Opportunities for improvement in the timing and delivery of MLT services
- Educational and training needs
- Provider and patient feedback

The recommended survey questions were submitted to L&I in Statement of Work (SOW) E2 Deliverable 3, in July 2021 for the following populations:

- Claim managers who have had workers in their case load with an MLT bill
- Workers with at least one bill for service by an MLT
- Attending providers of workers with an MLT bill
- Master's level therapists
- Master's level therapist association members

Subsequently L&I decided that there was no need for the attending provider survey and that L&I would survey the claim managers themselves. L&I also conducted interviews of the occupational nurse consultants (ONCs).

The survey questions for master's level therapists (pilot participants and non-participants) and workers were revised with input from L&I's subject matter experts and two psychologists at the University of Washington and submitted as SOW E-6 Deliverable 1 in December 2021.

Surveys were conducted online in 2022. This report submits survey results for (1) four groups of MLTs, (2) L&I claim managers (these surveys were conducted by L&I), and (3) workers who saw MLTs. The four MLT groups were those who were participating in the pilot at the time of the surveys, those who had withdrawn from the pilot, MLTs who completed the required training but didn't join the pilot, and MLTs who belong to professional associations in Washington state but weren't in any of the other groups. Appendices include the final survey versions.

[1] https://lni.wa.gov/patient-care/_docs/MLTPilotFAQs_2022Update.pdf

Abbreviations used in this document *master's level therapists (MLTs)* will refer to primarily three licensure groups: Licensed Marriage and Family Therapists (LMFTs), Licensed Mental Health Counselors (LMHCs), and Licensed Clinical Social Workers (LICSWs). *Associates* refers to MLTs who are still acquiring the experience needed for full licensure. *AP* refers to the Attending Provider for the L&I claim.

Response Rates

The response rate for MLT participants in the pilot was 63% but the other MLT groups' response rates and those of the workers were less than 50%. The answers and comments may not be representative of the whole population of especially the workers and other MLT survey respondents. Nonetheless, the survey results are useful for L&I's planning purposes and the comments have a wealth of ideas. In addition, the worker survey results must be interpreted keeping in mind that the workers identified were seeing the MLTs in 2020 and 2021, during the SARS Covid-19 pandemic.

Assessment of MLT Pilot Objectives

Access to care

Questions asked of the claim managers, MLTs and workers assessed access to care which all agree had improved. We were only able to survey workers who were treated by an MLT, and not those who were unsuccessful in obtaining care. Therefore, worker survey responses may not represent all experiences with access to care.

- A majority (69%) of those responding to the English survey said the AP selected the MLT for the worker, whereas this was the case for only 41% of those responding to the Spanish survey. A much higher percentage of Spanish survey respondents (38%) used the Find-a-Doc website to find their own therapist than English survey respondents (6%).
- A majority of claim manager survey respondents (69%) said 50% or less of attending providers were aware of the pilot. Nonetheless, respondents said that access to behavioral health interventions had improved (75%).
- MLTs' most reported benefit of the MLT pilot was increased access to support and treatment for workers.

Opportunities for improvement in the timing and delivery of MLT services

Most of the MLT pilot participants had no suggestions for improving the timing of treatments for workers. Similarly, there were not a lot of suggestions related to improving delivery of services, but there were many suggestions related to reducing the barriers MLTs experience in providing services.

Educational and training needs

Although the MLT Pilot participants felt prepared to treat workers and their concerns about returning to work after an injury, the surveys identified "pain management" as a training need as well as additional information about L&I processes and billing. To join the pilot, MLTs were required to complete a 3-hour online training which oriented them to the expected treatment methods for workers (e.g., CBT), gave an overview of some pain management techniques, and an orientation to L&I processes and billing. The survey comments suggest improvements in that training and trainings in other formats (e.g., a workshop and use of case studies).

Provider and patient feedback

Most (76%) of the MLT Pilot participants were satisfied or very satisfied with treating injured workers and the number of referrals they were receiving. MLTs seemed to think that the pilot was marketed too briefly and had a number of ideas for improving marketing to MLTs as well as addressing administrative barriers for the MLTs.

The majority of surveyed workers reported being satisfied with the care they received from their therapist and would recommend their therapist to a friend. Most also said the care from the MLT helped their recovery (61% English and 58% Spanish). When asked what helped most, the majority said it helped to have someone to listen to them or to have someone with empathy to talk to. There were very few workers who described less than ideal interactions with their MLT.

Other Survey Results

The major barrier to more MLTs participating is lack of awareness since only 5% of the MLTs participating in the survey of professional associations were aware of the MLT Pilot. A number of suggestions were made by the respondents about ways L&I can improve awareness among MLTs. The MLTs, when asked about ways to improve enrollment, mostly mentioned reducing administrative burden and paperwork, additional advertising, and higher pay.

Nearly all (88%) claim managers reported no change in the number of mental health diagnoses contended in their caseload.

A majority of claim manager respondents (75%) said that MLT-provided behavioral health services are the same or better than those provided by psychologists/ psychiatrists or psychiatric advanced registered nurse practitioners (ARNPs).

Conclusions

All groups responding agreed that access to care has been improved. The survey responses and comments provide ideas for increasing the number of MLTs enrolled and meeting the educational and training needs of MLTs when treating workers.

Most MLT pilot participants expressed satisfaction with treating workers and most workers were satisfied with the care received from the MLTs and would recommend the MLT to a friend. Most also felt the care from the MLT helped their recovery.

Recommendations

Suggestions are made for increasing the number of MLTs enrolled, meeting MLT educational needs, improving L&I administrative processes for MLTs, and improving the MLT experience and access for workers.

Chapter 1: Surveys of Master's Level Therapists

Survey Eligibility

Four similar online surveys were conducted of specific groups of master's level therapists: (1) MLTs who are participating in the pilot project (participants); (2) MLTs who did participate in the pilot project but have since withdrawn (referred to as "dropouts"), (3) MLTs who completed the required training but did not sign up for the pilot (referred to as "training only"), and (4) MLTs who were not part of any of these three groups but were members of one of the three professional associations listed below. Questions were tailored to each group but overall were quite similar. [See appendices 1-4]

Washington state professional associations for Master's Level Therapists:

- Washington State Society for Clinical Social Work
- Washington Mental Health Counselors Association
- Washington Association for Marriage and Family Therapy

Data Collection and Management

Study data were collected and managed using the Research Electronic Data Capture (REDCap) tool hosted at the University of Washington via Institute of Translational Health Sciences (ITHS) grant support (UL1 TR002319, KL2 TR002317, and TL1 TR002318 from NCATS/NIH).[1,2] REDCap is a secure, web-based software platform designed to support data capture for research studies, providing 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for data integration and interoperability with external sources.

Survey Recruitment

Survey invitations were sent via email and completed between March and November 2022 (Table 1). Participants, Dropouts, and Training only survey respondents were eligible to receive a $50 check as an incentive to complete the survey.

Table 1. *Survey completion dates*

	First Survey	Last Survey
Participants	17 March 2022	3 April 2022
Dropouts	10 March 2022	15 March 2022
Training only	21 April 2022	17 May 2022
Associations	31 August 2022	2 November 2022

L&I provided the email addresses for those who had ever signed up for the MLT pilot (participants and dropouts groups) then REDCap generated the email invitations. They received email reminders via REDCap every 4 days up to 4 times unless they completed the survey.

L&I staff sent the email invitations themselves to those who had completed the training but not signed up for the pilot (training only group). To ensure confidentiality of the survey participants the UW study team did not tell L&I who had participated, so a survey reminder email was sent to the entire group approximately 2 weeks after the initial invitation.

The final group, members of three state MLT professional associations in Washington state (associations group), were sent email invitations by their associations because the associations declined to share their email lists with the evaluation team for recruitment. The email invitations were either part of their regular email newsletter or a dedicated survey invitation email. Because the survey team had no way to limit the survey invitation reminders to only those who hadn't completed the survey, all association members received multiple recruitment invitations. Members were asked to complete a survey if they had not completed a prior survey about the pilot project.

The Washington Association for Marriage and Family Therapists' members started completing the survey August 31, 2022. They sent at least 1 reminder email October 6th as well as several social media posts in October. The Washington State Society for Clinical Social Work members began completing the survey September 2nd and the Washington Mental Health Counselors Association members on September 8th. They were asked to send reminders by the study team in mid-September and October. Reminders were embedded in the associations' newsletter or as a separate email.

The MLT surveys were kept open for 8-9 weeks.

Response Rates

Table 2*. MLT group recruitment numbers and response rates*

	Participants	Dropouts	Training only	Associations
Invitations sent	64	9	58	thousands
Surveys	40	4	14	99
Repeat surveys			-3	
Total	40	4	11	99
Response rate	63%	44%	19%	unknown

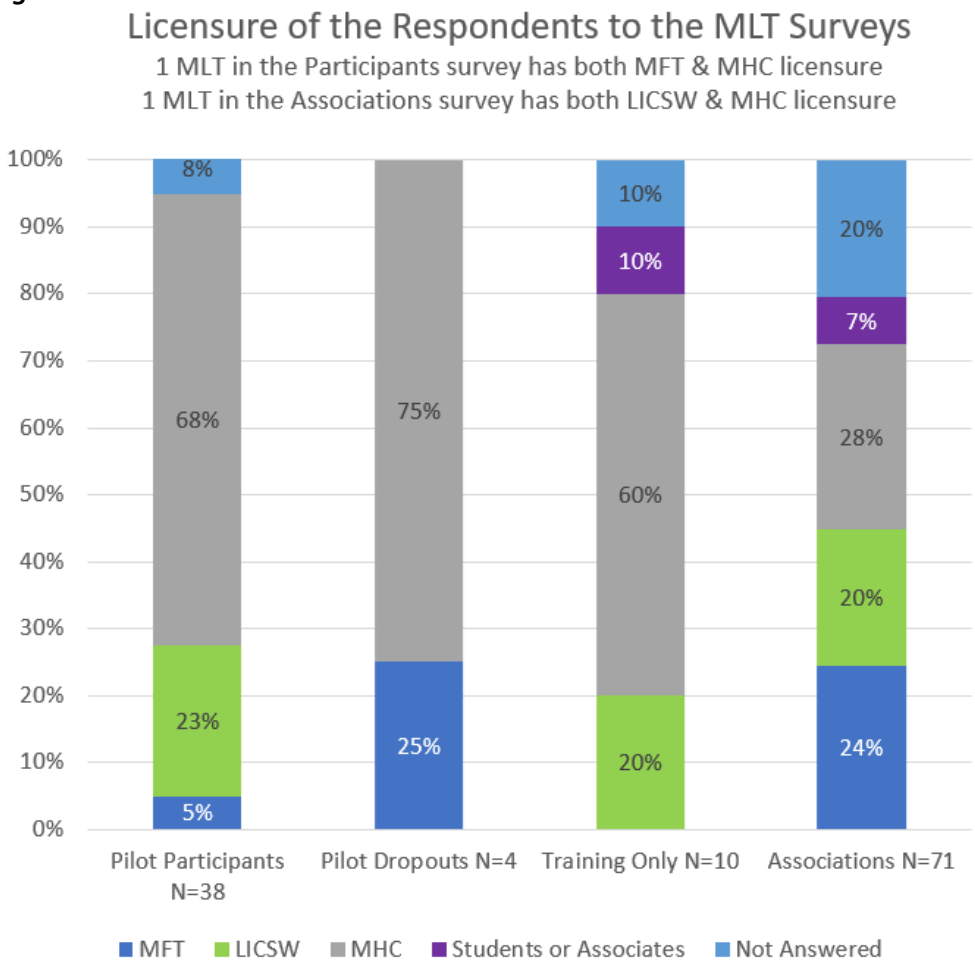
- Among MLTs participating in the L&I pilot, 63% responded.
- Among MLTs who were initially participating in the L&I pilot, but then discontinued, 44% responded.
- Among MLTs who completed the L&I training but who were not participating in the L&I pilot, 19% were successfully recruited.
- Denominator numbers for the MLTs recruited through their professional associations are not known. Although membership numbers estimates were obtained (Washington Association for Marriage and Family Therapy - 934, Washington State Society for Clinical Social Work – 1260, and Washington Mental Health Counselors Association - 1000), the numbers of those on their email distribution lists is likely less. Participation rates are estimated at roughly 3% from each association.
- One MLT completed 3 surveys: 2 training only surveys and one dropout survey. The 2 training only surveys were excluded from results analyses.

- Another MLT completed a training only survey but said in a comment that they were now participating in the pilot. This MLT was invited to complete a "participant" survey and the training only survey was excluded from analyses.

MLT Licensure

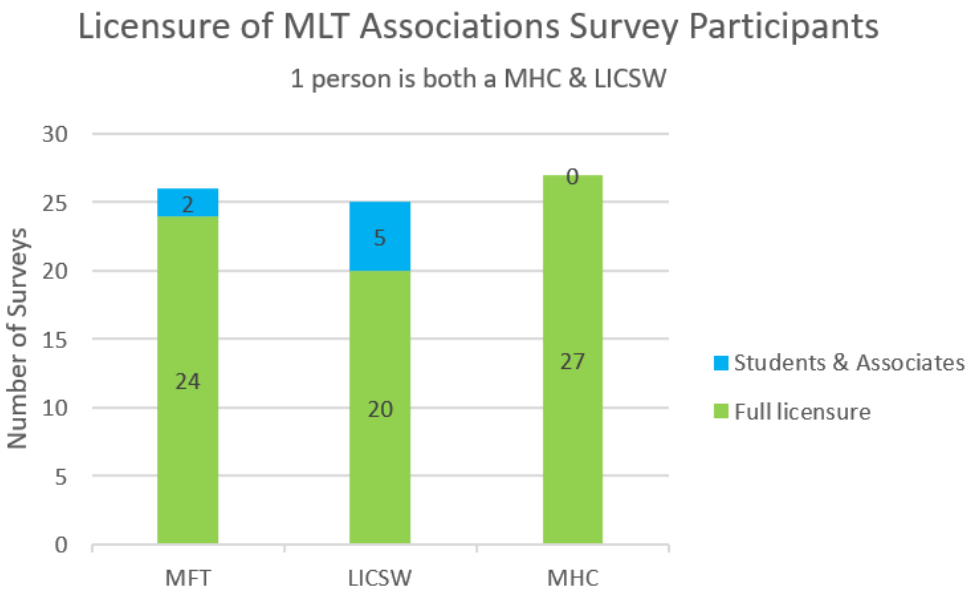
The licensure of the survey participants can be seen in Figures 1 & 2 although not all respondents answered this question. Those with Mental Health Counselor (MHC) licensure were the majority of participants for each survey although not nearly so dominant in the survey of association members. Licensed Social Workers (LICSW) were approximately a fifth of the participants in three of the surveys (participants, training only, and associations). Marriage and Family Therapists (MFT) were a quarter of the participants in the dropout and association surveys.

Figure 1.



One pilot participant also listed certification as a Disability Management Specialist (CDMS).

Figure 2.



Survey Results

For some surveys the MLT completed the consent questions but did not answer any additional questions. Table 3 shows the final number of survey respondents for each group. The numbers reported in the results below may vary because some respondents did not answer all questions.

Table 3*. Number of completed surveys by MLT groups*

	Participants	Dropouts	Training only	Associations
Surveys (from Table 2 above)	40	4	11	99
Surveys with only consent questions completed			-1	-4
Surveys with useable data	40	4	10	95

Open-Ended Question Responses

Two team members, TSW & DE, reviewed the open-ended question responses and grouped them into categories. The categorizations were then compared and when there were disagreements, they were reviewed and reconciled. All open-ended responses can be found in Appendices 1B, 2B, 3B, and 4B.

Awareness of the Pilot Project and Referrals

The respondents to the survey of the professional associations' members were asked if they had heard about L&I's MLT pilot project before receiving the survey invitation.

Table 4. Heard of MLT pilot project? *N=95*

Yes	5%
No	95%

Most (95%) of the respondents did not know about the L&I MLT pilot project. The other 3 MLT groups were not asked this question.

Everyone was asked how they heard about the MLT pilot project. This was an open-ended question, but the responses fell into a limited number of categories shown in Table 5.

Table 5. How did you hear about the MLT pilot project?

	Participants N=40	Dropouts N=4	Training Only N=10	Associations N=5
Colleague	28%	25%	10%	
Employer	18%	25%	10%	
Professional Assoc				60%
Job posting, interview or recruiter	12%			
L&I	25%		30%	
Provider	3%		10%	
Client	3%	25%		
Attorney				20%
Email (unspecified)			20%	20%
Don't remember / Unclear		25%	10%	
Online / research	12%		10%	
Total	100%	100%	100%	100%

A few questions asked whether the MLT treats injured workers and whether they receive referrals. In all but the associations survey, most (80-100%) of the respondents reported treating injured workers (Table 6). Of the two (5%) pilot participants who said they don't treat injured workers, one had retired and the other was "no longer interested."

Table 6. Do you treat clients with work injuries? (Regardless of payment type)

	Participants N=40	Dropouts N=4	Training Only N=10	Associations N=95
Yes	38 (95%)	4 (100%)	8 (80%)	47 (49%)
No	2 (5%)	0	2 (20%)	48 (51%)

Ten (25%) of the pilot participants said they had not treated and been paid in the L&I pilot (Table 7). Four of the 10 said in a later response that they hadn't seen any workers yet. Another said they had seen one worker but L&I didn't pay. They didn't know why L&I didn't pay so they billed the worker's insurance. One said "As I was starting up my private practice, I thought L&I patients might become one type of patient/client type for me. However, after signing up, I specialized in a different direction." Another of those with too few referrals said they support a primary care practice, so perhaps haven't seen any workers because none have come through that practice yet. Six of the ten who said they had not been

paid by L&I said that they receive too few referrals. The others said they receive the right number of referrals, but one of those said they had no time for workers because of the increase in community demand.

Table 7. Have you treated clients in L&I's MLT pilot project and been paid by L&I?

	Participants N=40	Dropouts N=4	Training Only N=10	Associations N=95
Yes	75%	100%	0%	1%*
No	25%	0%	100%	99%

*Possible error since an associate.

The pilot participants who had seen L&I workers were asked about the percentage of their practice that are injured workers (Table 8). The most common response was "less than 10%."

Table 8. Thinking about your entire client load, what percentage of your clients pay with L&I?

	Participants N=30
<10%	37%
11-25%	13%
26-50%	13%
51-75%	3%
>75%	33%

The majority of MLTs who had or are participating in the pilot were happy with the number of referrals they receive from this pilot (Table 9).

Table 9. I receive [too many / the right number / too few] referrals from this pilot.

	Participants N=40	Dropouts N=4	Training Only* N=3	Associations N=0
Too many	3%	0%	33%	NA
The right number	68%	75%	33%	NA
Too few	30%	25%	33%	NA

*Asked only of the 3 Training Only survey respondents who said they receive referrals to treat injured workers. They were asked the following question as well since they wouldn't be treating the referrals they received.

How do you handle those referrals? (3)

- "I agree to see the client if they will pay with insurance or cash or we had one of our PhD providers see the individual depending on clinical presentation"
- "I assess if I am the appropriate therapist for the client."
- "I provide biofeedback treatment to the patients referred to me under my biofeedback credentials."

Questions about Training and Knowledge

Questions were asked about relevant training and background for treating injured workers (Table 10 and following open-ended responses). Half or more of the MLTs had worked or trained as employee assistance program therapists and 40% of the pilot participants had worked or trained as vocational counselors.

Table 10. Have you worked or trained as a _____ ? *(could answer yes to each)*

	Participants N=40	Dropouts N=4	Training Only N=10	Associations N=90
Vocational counselor	40%	25%	20%	13%
PGAP activity coach	10%	0	10%	0%
Employee Assistance Program therapist	60%	50%	50%	48%

What other background do you have that you've found useful (or think would be useful) in treating clients with work injuries?

Pilot Participants – 40 answered:

The most frequent answers were the following:

- Vocational rehabilitation (9)
- Dialectical behavior therapy (DBT), Cognitive behavior therapy (CBT), Acceptance and commitment therapy (ACT), other problem-solving/solution-based treatments (7)
- Pain (7)
- Mental health including depression & anxiety (7)
- Trauma (6)

Pilot Dropouts – 3 answered:

Three of those who had withdrawn from the pilot listed a number of things but only CBT skills were mentioned by more than one person. The others mentioned were Spanish speaking skills, Employee Assessment Program (EAP), motivational interviewing (MI), substance use disorder (SUD), trauma-informed approach, grief work, EMDR (Eye Movement Desensitization and Reprocessing), lots of work with men and support groups, stress reduction and relaxation exercises, experience with depression, anxiety and post-traumatic stress disorder (PTSD).

Training only – 10 answered:

- Pain treatment experience (4)
- Clinical experience (2)
- Trauma treatment experience (2)
- Other things mentioned: personal experience as a client, disability experience, experience treating anxiety, and compassion

Associations – 54 answered:

- Mental health training / experience (17)
- Trauma training / experience (14)
- None / not applicable (NA) / Not sure (11)
- Pain experience / training (8)
- Other types of medical or vocational experience/jobs (7)
- Personal experience (7)
- EMDR (4), Mindfulness (4), Somatic experience (4),
- Addiction/substance use training (4), Health psych/chronic illness experience (4)
- Family/couples experience (3), DBT (3), medical social work (MSW) training (3)
- Others mentioned: CBT (2), International Coaching Foundation (ICF) coach training, hypnosis, systems theory

Preparation to Treat Injured Workers in the Pilot. All the pilot participants and dropout respondents felt somewhat or completely prepared to treat a client with a work injury as did the majority of the respondents to the training only and association surveys (Table 11).

Table 11. Based on your prior experience and education do you feel adequately prepared to treat a client with a work injury?

	Participants N=39	Dropouts N=4	Training Only N=10	Associations N=87
Not at all prepared	0	0	0	5%
Somewhat unprepared	0	0	0	9%
Neither unprepared or prepared	0	0	10%	17%
Somewhat prepared	18%	25%	30%	45%
Completely prepared	82%	75%	60%	24%

A majority of each group felt somewhat or completely prepared to treat a client's concerns about returning to work after a work injury (Table 12).

***Table 12.* Do you feel prepared to treat a client's concerns about returning to work after a work injury?**

	Participants N=39	Dropouts N=4	Training Only N=10	Associations N=87
Not at all prepared	0	0	10%	5%
Somewhat unprepared	3%	0	0	9%
Neither unprepared or prepared	0	0	10%	17%
Somewhat prepared	18%	0	10%	45%
Completely prepared	79%	100%	70%	24%

Respondents were also asked about their knowledge of pain as well as their training in pain management techniques and confidence in the preparation for treating a client with pain. A majority of each group said they were familiar with the biopsychosocial model of pain (Table 13). However, a small

percentage of those completing the associations survey (8%) and the pilot participants (3%) said they were not at all familiar with the model.

Table 13. How familiar are you with the biopsychosocial model of pain?

	Participants N=39	Dropouts N=4	Training Only N=10	Associations N=89
Not at all familiar	3%	0	0	8%
Slightly familiar	5%	0	20%	19%
Somewhat familiar	10%	0	0	10%
Moderately familiar	28%	75%	30%	35%
Extremely familiar	54%	25%	50%	28%

A majority (63% to 100%) of each group also felt prepared to treat clients with pain, with only some of those responding to the associations survey saying they were "not at all prepared" (8%).

Table 14. Do you feel prepared to treat clients with pain?

	Participants N=39	Dropouts N=4	Training Only N=108	Associations N=86
Not at all prepared	0%	0	0	8%
Somewhat unprepared	0%	0	0	19%
Neither unprepared or prepared	3%	25%	0	10%
Somewhat prepared	36%	50%	40%	36%
Completely prepared	62%	25%	60%	27%

A majority of those completing the pilot participants (83%) and training only (70%) surveys said they had had training in specific pain management techniques (Table 15). Only half the pilot dropouts and 36% of those completing the associations survey reported training in pain management techniques.

Table 15. Have you had training in specific pain management techniques?

	Participants N=39	Dropouts N=4	Training Only N=10	Associations N=86
Yes	83%	50%	70%	36%
No	15%	50%	30%	64%

If yes, what type of training have you received?

Pilot participants – 33 answered:

The pilot participants who provided information about their pain management training mentioned CBT (9), mindfulness (7), biofeedback (7), pain psychology or generic pain management training (6), master's degree course work (5), acceptance commitment therapy (4), DBT (4), pain reprocessing therapy (2), motivational interviewing (2), hypnotherapy (1), EMDR (1), trauma informed yoga (1), Cognitive Processing Therapy, Problem Solving Treatment,

Behavioral Activation (1), and "training in IFS [internal family system] models, training in attachment and trauma models" (1).

Pilot Dropouts – 2 answered:

The two who withdrew from the pilot mentioned biofeedback and stress management, creative visualization and relaxation, CBT, ACT, trauma focused CBT, and DBT.

Training only – 7 answered:

Those who completed the training but didn't join the pilot mentioned a lot of different evidence-based techniques relevant to pain. The most frequently mentioned were mindfulness (4), CBT (3), ACT (3), and biofeedback (2).

Associations – 31 answered:

The respondents recruited by the associations also listed a number of types of pain management training: mindfulness /meditation and variations (17), CBT for pain (including relaxation, guided imagery) (12), EMDR (5), variations on somatic therapy (5), generic pain training (5), hypnosis (4), ACT (3), and yoga (2) as well as others only mentioned once.

When asked about the training the MLTs were required to complete to participate in the pilot, the majority said it was "somewhat helpful" or "very helpful" (Table 16).

Table 16. How helpful was the required L&I MLT pilot training in preparing you to treat a client in this pilot?

	Participants N=39	Dropouts N=4	Training Only N=10
Prefer not to answer	8%	0	10%
Not at all helpful	13%	0	20%
Slightly helpful	18%	25%	10%
Somewhat helpful	41%	75%	40%
Very helpful	21%	0	20%
Extremely helpful	0%	0	0

What helped the most? [asked of MLTs who thought the training was at least slightly helpful]

Pilot Participants' – 31 responses:

- Understanding the process/program/overview (8)
- Administrative requirements, including forms, system payment & rules (6)
- Delivery of the content (e.g., website, slides & videos, etc.) (5)
- Support (e.g., ability to get questions answered) (3)
- Treatment parameters (3)
- Don't remember (3)
- Other: what to expect (2), biopsychosocial model (1)

Pilot Dropouts – 4 answers:

- "I took that over two years ago, and don't remember it well now. It makes it difficult to answer this question. I do remember taking lots of notes, and feeling like I felt more grounded and prepared after taking it."
- "Understanding the chronic nature of some injuries which often led to depression and anger …and extended time frame for treatment and recovery. Some clients in the system for years."
- "Information about L&I and what clients are experiencing"

Training Only – 7 answers:

- Goals and expectations of the project
- Don't remember
- Billing details

All participants were then asked ***What could have helped you more?***

Pilot Participants' – 39 answered:

- More about billing and billing codes (9)
    - "Clearer directions", "simpler explanations", "exact directions,"
    - "Discussion of other billable codes for ancillary contacts that LNI wants"
- Other (8)
    - "Perhaps incorporating other stakeholders in the training to speak about their experience with injured workers."
- Different training format (8)
    - "8 to 16 hour in-person CEU training at Lake Chelan"
    - "More specific training using actual case studies"
    - "A workshop with some basic strategies"
    - "Access to the training for repeat viewing/review"
    - "I was trained by another MLT participant in addition to the LNI training. I would have had questions after the LNI training alone, but not because it was not clear, but it's helpful to have samples, etc. I think if someone is available to answer

questions and provide clarification or maybe even examples, it would be good for someone not otherwise trained."
    - "Something physical to reference"
- Can't really remember / not sure / not applicable (7)
- Ongoing continuing education or where to find more education (3)
    - "More regular training, reminders, updates and the opportunity to connect with other MLT providers in an organized format such as a monthly or quarterly Zoom meeting."
    - "Further education to assist workers"
    - "Pain management"
- Documentation (2)
- More information on non-billing L&I processes e.g., referrals (3)

Pilot Dropouts – 2 answered:

- More assessment tools
- Pain management and training around working in a bilingual setting, awareness about cultural influences

Training only – 3 answered:

- Additional information on how to properly complete the SOAP (Subjective, Objective, Assessment, Plan) format.
- Maybe videos of actual clips from sessions of what the sessions would look like.
- Session note templates

What additional training or education would be helpful for treating clients with work injuries? (This was asked of all taking the survey.)

Pilot Participants – 39 responded:

- Most (11) said "pain management"
- 8 mentioned more about L&I and/or L&I processes (8)
- Specific training (not including pain management) (7)
- Some (5) mentioned the need for ongoing support & training for the MLTs
- Some were unsure (5), had nothing to add (5) or said a variety of other things (5)
- Some wanted training around return to work (3)
- Two mentioned providing continuing education credits (2)

Pilot Dropouts – 2 answered:

- DBT
- "I think support groups would be helpful for clients feeling angry, frustrated, lonely and disconnected."

Training only responses can be read in Appendix 3b.

Associations – 78 responses

Appendix 4B has the responses of those who were recruited to the survey from the professional associations. When reading their responses to this question, keep in mind that they are not pilot participants and thus have not gone through the current training module so they don't know what training already exists.

The L&I MLT training has a slide or two about the Psycho-social Determinants Influencing Recovery Resource (PDIR). The pilot participants and dropouts who completed that training were asked about their familiarity with this resource. Half or more said they were not familiar with the PDIR in spite of the training (Table 17). The 15 individuals who were familiar with it were asked if they use it or recommend it to Attending Providers (Table 18). Of the 13 pilot participants who were aware of the PDIR, 8 (62%) used the PDIR or recommended it to attending providers.

Table 17. Are you familiar with L&I's Psycho-social Determinants Influencing Recovery Resource (PDIR)?

	Participants N=39	Dropouts N= 4	Training Only N= 0	Associations N=0
Yes	33%	50%	NA	NA
No	67%	50%	NA	NA

Table 18. If yes, do you use the PDIR or recommend it to Attending Providers?

	Participants N=13	Dropouts N=2	Training Only N=0	Associations N=0
Yes	62%	0	NA	NA
No	38%	100%	NA	NA

Questions about Treating Injured Workers

MLTs who had treated workers and been paid were asked a number of questions about the treatments they used, the conditions they addressed, the psychosocial barriers to recovery and types of clients they treated and what worked well or not so well.

Barriers to Recovery. The most frequently mentioned barriers to recovery addressed by those still participating in the pilot were fear of re-injury, sleep, pain coping, and mild depressive and anxiety symptoms (Table 19). Least frequently checked by the pilot participants was treatment adherence (53%), whereas deactivation / inactivity were least mentioned (25%) by the pilot dropouts. Those who had dropped out of the pilot all said pain coping and catastrophic thinking were addressed.

Table 19. Which psycho-social barriers to injury recovery have you addressed with workers in this MLT pilot? (select all that apply)

	Participants N=30	Dropouts N=4
Deactivation / inactivity	70%	25%
Fear of activity	80%	50%
Fear of re-injury	90%	75%
Catastrophic thinking	80%	100%
Sleep	90%	75%
Treatment adherence	53%	75%
Pain coping	90%	100%
Self-efficacy	77%	75%
Recovery expectations	80%	75%
Perceived injustice	77%	75%
Loss of workplace connection	67%	50%
Mild depressive symptoms not meeting diagnostic criteria	90%	50%
Mild anxiety symptoms not meeting diagnostic criteria	93%	50%
Other	37%	25%

Barriers mentioned by the pilot participants in the "other" category were:

Pilot Participants – 11 answered:

- Trauma, PTSD, diagnosable mental health disorder (4)
- Other basic needs (e.g., financial, lack of access to medical services outside L&I, rent/food) (2)
- Delays in treatment (4)
- Others (4): Self-esteem, loss of connection with others, identity, grief and loss of able-body

The one dropout survey respondent who answered this question said that the other psychosocial barriers addressed were: "Post-trauma symptoms. Grief work related to accepting/reframing the losses associated with injury."

At least 50% of the pilot participants reported that the MLT pilot worked well for all the barriers to recovery which they were asked about (Table 20). All the pilot dropouts said the pilot worked well at addressing catastrophic thinking. Most pilot participants said the pilot worked well for mild anxiety symptoms (87%).

Table 20. **For which barriers to recovery does the L&I MLT pilot work well?** (select all that apply)

	Participants N=30	Dropouts N=4
Deactivation / inactivity	50%	50%
Fear of activity	67%	50%
Fear of re-injury	67%	25%
Catastrophic thinking	77%	100%
Sleep	63%	50%
Treatment adherence	50%	25%
Pain coping	67%	75%
Self-efficacy	70%	25%
Recovery expectations	70%	25%
Perceived injustice	57%	25%
Loss of workplace connection	50%	50%
Mild depressive symptoms not meeting diagnostic criteria	80%	50%
Mild anxiety symptoms not meeting diagnostic criteria	87%	50%
Other	23%	25%

Approaches Used. The most frequently used approaches by the pilot participants were cognitive behavioral therapy (CBT) (87%) and mindfulness-based techniques (87%) (Table 21). All of the listed approaches except exposure-based therapies, dialectical behavioral therapy, and psychoanalytic techniques were used by at least 50% of the current pilot participants.

Table 21. What modalities or approaches have you used when treating the workers in this MLT pilot? *Select all that apply***.**

	Participants N=30	Dropouts N=4
Relaxation/guided imagery	77%	100%
Cognitive behavioral therapy (CBT)	87%	100%
Prolonged exposure and other exposure-based therapies such as Cognitive Processing Therapy (CPT) or Eye Movement Desensitization and Reprocessing (EMDR)	40%	0
Mindfulness-based techniques	87%	100%
Acceptance and commitment therapy (ACT)	60%	0
Dialectical behavioral therapy (DBT)	33%	100%
Psychoanalytic techniques	27%	25%
Physical activity or exercise	60%	75%
Activity Pacing	63%	0
Sleep hygiene/sleep restriction	77%	50%
Motivational interviewing	77%	75%
Problem solving therapy	80%	75%
Supportive therapy	80%	25%
Other (please describe)	13%	25%

The 4 individuals who selected the "other" option added the following:

- Holistic (vitamins/supplements)
- Trauma therapy
- Problem Solving Treatment
- Psychoeducation

For what types of conditions does the L&I MLT pilot program work well?

Pilot Participants:

- Anxiety and / or trauma (13)
- Depression (12)
- All or most (6)
- Stress, grief, frustration re: RTW [return to work] (5)
- Return to work (3)
- Don't know (3)
- Pain (2)
- Traumatic brain injury (2)

Pilot Dropouts – 3 answered:

- "Significant mental health symptoms that qualified for diagnoses such as major depressive disorder, PTSD, and anxiety disorders. Also worked well for someone that L&I providers seemed to suggest her reports of pain might be "all in her head" and our work together revolved mostly around pain management and supporting her to strengthen her self-advocacy skills and supports."
- "Adjustment (depression, anxiety, grief)"
- Virtual therapy

For what types of conditions does the L&I MLT pilot program NOT work well?

More than one Pilot Participant mentioned the following:

- Complex or severe mental illness (5)
- Pre-existing mental illness (5)
- Chronic pain (2)
- Substance use (2)
- Severe injuries (2)

Pilot Dropouts- 3 answered:

- "More severe symptoms such as psychotic symptoms, suicidality or other safety issues, the structure is not right for treatment and they need more comprehensive services from a dedicated provider"

- "Personality disorders. Clients stuck in a system with long waits, and negative interactions with providers/ psychologists. Seems like many clients are waiting for another round of surgeries that may or may not help."
- "Short-term, b/c there's a LOT to cover within a limited amount of sessions"

For what types of clients does the L&I MLT pilot program work well?

Pilot Participants – 29 answered:

- Those wanting or needing support (9)
- Motivated clients (7)
- All (7)
- Those with resources (3)
- Early phase or not chronic (2)
- Don't know (2)

Pilot Dropouts – 3 answered:

- Temporary relief
- "Motivated. Enjoys working. Supportive family. Clients who are resilient and see opportunities to gain new skills and reinvent themselves."
- "Dealing with chronic pain and limitations in their life roles (work, family, recreation, etc.) post-injury. Less engaged with vocational processes than they need to be (getting back to work)."

***For what types of clients does the L&I MLT pilot program NOT work* well?**

Pilot Participants – 29 answered:

- Those not motivated to return to work or malingering (8)
- Severe mental illness/pre-existing severe mental illness (5)
- Not sure / no answer (4)
- Substance abuse (3)
- Social barriers / multiple challenges (2)
- All (2)
- Other (9)

Pilot Dropouts 3 answered:

- Trauma and SUD [substance use disorder]
- "Complaining. Perceived injustice. Clients who are not able to be responsible with maintaining scheduled appointments."
- "Severe mental health symptoms (this might only become apparent once treatment has started, so then would need to be referred). No significant mental health symptoms being reported."

Nearly half of the pilot participants said they typically had 13-16 visits with workers in the pilot (Table 22). At the beginning of the study period the MLTs would have had to obtain authorization after 8 visits for additional visits.

Table 22. **On average, please estimate how many visits you typically have with an injured worker?**

	Participants N=29	Dropouts N=4
1-4	0	25%
5-8	14%	50%
9-12	38%	25%
13-16	48%	0

When asked whether the pilot allowed enough visits to adequately address the issues seen, 40-50% of both groups were neutral, about 24% of each group agreed, and 25-34% disagreed (Table 23).

Table 23. **The MLT pilot allows enough visits to adequately address the issues.**

	Participants N=39	Participants who saw IWs, N=30	Dropouts N=4
Strongly disagree (1)	13%	10%	0
Disagree (2)	21%	24%	25%
Neither disagree or agree (3)	44%	41%	50%
Agree (4)	23%	24%	25%
Strongly agree (5)	0	0%	0
Mean	2.8	2.7	3

Mental Health Evaluations

The majority of the pilot participants (72%) had recommended a mental health evaluation to a provider (Table 24). Of the pilot participants, 62% treated a worker after recommending the mental health evaluation, which contributes to continuity of care (Table 25).

Table 24. Have you suggested a mental health evaluation to the attending provider of a worker in the pilot? [Asked only of those who treated injured workers]

	Participants N=29	Dropouts N=4
Yes	72%	50%
No	24%	50%
Other	3%*	0

*The one (3%) other comment was not related to the question.

Table 25. If yes, have you treated a mental health condition after you suggested a mental health evaluation, the attending provider requested it, and a mental health condition was approved?

%	Participants N=21	Dropouts N=2
Yes	62%	
No	38%	100%
Other		

Questions about Satisfaction, Benefits and Improvements

Most (76%) of the MLT Pilot Participants were satisfied or very satisfied with treating injured workers and 17% were neutral (Table 26). Only 7% reported being dissatisfied.

Table 26. How would you rate your overall satisfaction with treating L&I's injured workers?

	Participants N=29	Dropouts N=4
Very dissatisfied	0%	
Dissatisfied	7%	50%
Neither satisfied or dissatisfied	17%	
Satisfied	59%	50%
Very satisfied	17%	

Two open-ended questions asked those who had participated in the pilot (current pilot participants and dropouts) about the benefits of the pilot and what went well with the pilot.

What are some benefits of the pilot? For example, to workers, or your practice, etc.

Pilot Participants – 39 answered:

- Benefits to workers:
  - Increased access, support and treatment (24)
  - Getting them back to work or rehab (4)
- Benefits to therapists:
  - Rewarding work (10)
  - A source of referrals (2)
  - Increased coordination between Occupational Medicine and Behavioral Health (1)
  - None (3) including 2 who said they never got paid
- Didn't know (4)

Pilot Dropouts -- 3 answered:

- "It appeared to help clients with their mental health barriers."
- "Venting. Getting on meds with the encouragement of a therapist. Willing to adapt to circumstances beyond their control."

- "The physician's office folks seemed relieved to have this added service for some of their clients that they saw struggling. Some of the clients themselves made notable improvements in their sense of empowerment, acceptance and connection to natural supports and loved ones. I was able to work flexibly and my work was made straightforward and able to remain focused on the clients, because the physician's office managed much of the paperwork/billing."

From your experience, what has gone well in the pilot program?

Pilot Participants – 39 answered:

- Benefits workers (9) – "I have seen many clients improve their mental health and motivation to continue putting as much effort as possible into their physical recovery. This assists other providers and I believe that improved mental health has led to a smoother transition in return to work."
- Availability of services to patients/access to providers (9)
- Increasing the number of allowed sessions (6)
- Unsure / don't know (5)
- Process went well (4)
- Improved care/care coordination (3)
- Referrals/getting to see L&I patients (3)
- Payment process (2)

Pilot Dropouts -- 3 answered:

- Worker benefits
- Collaboration
- "Making solid connections with people and providing support during a difficult time. Fairly compensated, except for no shows."

A series of five questions and their follow-ups identified opportunities for improving the MLT pilot project.

What challenges or difficulties have you experienced with this pilot program?

Pilot Participants – 39 answered:

- Paperwork / charting/pre-approval (13)
- Not getting paid (2) / billing system / pay amount (7)
- Limited/no referrals / referral process (6)
- Coordination (5)
- Communication (3)
- No access to chart (3) – "MLTs only have access to the Claim and Accounts Center (CAC) when the VRC [vocational rehabilitation counselor] works for the same company. This can leave the MLT a bit out of the loop and at times the other providers on the claim expect that the MLT has information that he/she doesn't have."
- Interpreter service issues (3)

- Too few sessions (2)
- Other (8) – "I think that all clinicians who are providers with L&I should be notified when any changes or updates to policies occur, as my program manager did not hear about this revised policy until March 15th and did not notify any of us other clinicians. The in-person evaluation required once every 6 months is unclear and needs to be clarified if that is referring to psychological evaluations once every 6 months. Also, if there is any type of in-person requirement for clients engaging in telehealth this is going to create issues for clients who live in rural areas and are not near a clinician for an in-person visit. Also, there are many clinicians who are not offering in-person sessions, myself included, as I think we have learned how effectively telehealth therapy has been for the 2 years it's been utilized due to the pandemic."

Pilot Dropouts -- all 4 answered:

- "People want to continue services past the initially offered sessions, but can't continue"
- "Client's lack of attendance"
- "Keeping track of paperwork flow in addition to billing for regular clients."
- "Wasn't always able to talk with the client's main coordinator of services which might have provided the perspective that could have helped me better support the client. When that conversation happened, it was very beneficial for understanding their struggle."

Table 27. Have you experienced any administrative or procedural barriers that delayed or affected the quality of your services to the workers in this pilot?

	Participants N=29	Dropouts N=4
Yes	83%	25%
No	17%	75%

If yes, please describe

Pilot Participants – 23 answered:

- Authorization process & delays (utilization review) (11)
- Billing (4)
- Not getting answers to questions / communications issues (4)
- Training needed (2)
- Gaps in care / more care needed (2)
- Other (5) – e.g., "The amount of paperwork, difficulties with referral process, and coordination"

The one who had withdrawn from the pilot said "mostly paperwork, lack of in person sessions, and lack of no-show compensation."

If yes, do you have suggestions about how to reduce those barriers?

Pilot Participants – 24 answered:

- The problem has resolved (8) [Utilization review]
- Increase / improve LNI admin support of MLTs (4) – "I think a monthly or quarterly MLT Zoom call would be helpful in connecting MLTs and answering questions. In addition, it would provide some quality assurance/improvement because LNI would be able to remind or clarify MLTs of issues that are regularly coming up. Improvement of communication between LNI and MLT providers is a must."
- Training needed (e.g., for claim managers) (3)
- Billing related (3)
- Other (4) – "Stop using IME's [Independent Medical Examination] or remove the IME providers who provide rubber stamp opinions for no other reason except to get another referral."
- Not sure / don't know (3)
- Fix and simplify procedures (2)

The one pilot dropout said "Reduce paperwork. Tell clients they will be responsible for missed appointments."

What suggestions do you have for improving the timing of treatment for workers in this pilot?

Pilot Participants – 39 answered:

- No suggestions (13)
- Referrals early in the claim (10) – "Treatment should begin immediately and be referred by L&I, not an attorney." "Having AP's refer anyone who's been injured more than 3 months to a counselor"
- Other (9) – "More therapists that are bilingual"
- More sessions (4)
- Training of providers (3) – "Continuously educating the community- Attending Providers (APs), VRC and other stakeholders- regarding the program so they will refer workers when needed, without delay."

Pilot Dropouts -- 2 responded:

- "Extend the lengths of treatment"
- "Ensure that the treatment occurs early in the claim for most benefit"

What suggestions do you have for improving the delivery of services to workers in this pilot?

Pilot Participants – 38 answered:

Most had no suggestions (16). Some mentioned procedural improvements (6):

- "A cheat sheet or reference site with a flow chart with each step and requirement and links to each document to aid in providing all required info"
- "Allow access to CAC"

A few mentioned telehealth related suggestions (4), referral related improvements (3), suggestions related to behavioral health intervention (BHI) timing or duration (3), and improved coordination with and education of providers (3).

- "Have a questionnaire for referrals to complete that can be considered for therapeutic appropriateness by each therapist."
- "Telehealth is essential as many workers are unable to travel far (or at all) given their injuries. The suggestion is that these services remain as they are."
- "Do not allow clients to be referred to the same company or one that is wholly owned by a vrc firm. It violates the kickback prohibition on my professional license. In some cases the MLTs work as vrc in the same firm getting shared clients. Really????? Dual relationships!"

Pilot Dropouts -- 2 responded:

- "More trainings for therapists"
- "Motivational interviewing with client prior to making referral?"

What other suggestions do you have for improving the pilot?

Pilot Participants:

- None (21)
- More flexibility in treatment (7)
- Billing/admin suggestions (4)
    - "Considering the amount of outside time involved in communication with L&I/MD's etc., the pay is not on scale with private insurance companies."
    - "Allow travel/mileage reimbursement to counselors so we can meet with clients near their homes, i.e. other offices our companies have. This would also allow us to provide more BHI services to those in need."
- More or different training (3)
- Other (4):
    - "I wish it seemed like LNI wanted to hear feedback from MLT providers to help make improvements. We are now two years into the pilot and this is the first time I've been contacted like this and that is a little disappointing. … I'm grateful that it seems we were heard in the case of issues with Comagine however I was disappointed in how long it took for LNI to respond and make the necessary changes."

- "Give the information about the program to the injured worker right away and keep it voluntary for them"
- "Partner with big tech companies to get clients seen (Headway, Alma, Lyra, etc.)"

Pilot Dropouts -- 2 answered:

- "Extend the amount of sessions for qualified workers"
- "Keep the program"

Questions Related to Expanding the Pilot

Two questions and their follow-up questions explored issues related to expanding the number of MLTs participating in the pilot.

L&I would like more MLTs to participate in the MLT pilot program. What do you suggest to increase MLT enrollment in the program?

Pilot Participants – 38 responded:

- 24% had no suggestions (9)
- Reduce paperwork / admin barriers (8) – "Reduce paperwork. If it takes three time slots to see client and complete paperwork, therapists are not able to see the number of clients that they would like to. When there is such a need for service, therapists have to make choices about who they can serve."
- Publicize it more / better (8)
- Pay more (7)
- Training related (3) – "Engage in better education from your case workers as to how to provide this service"
- "In my experience as the Behavioral Health Program Manager, recruiting the right people is key, and providing them with a lot of guidance that they need in order to meet LNI's expectations and understand this complicated system. A background in voc rehab is very helpful for this. I can imagine it would be very difficult for someone in private practice to find out about the pilot, clearly understand the expectations, and learn the system on their own. I would be shocked if LNI had any MLT providers participating in the pilot who have experienced that."
- "The issue really is that most MLTs have no orientation or understanding the goals and objectives of LNI or the related laws. So there's few out there that you would want."

Only two of the pilot dropouts answered this question:

- "Reach out to providers directly"
- "Well it's therapists, so... Pay them well. Make the paperwork/reimbursement as easy as possible. Give them scheduling flexibility. And I'll also add, be selective and make sure that they are trained in the approaches that will most benefit for brief therapy with depression, post-trauma, anxiety and complicated grief. CBT approaches including structured CBT trauma treatment and DBT. motivational interviewing. Strengths-based. Multicultural services training."

Training Only – 9 answered:

- Administrative improvements (3)
- Advertising and marketing (3)

Other things mentioned: "training/mentoring of early career MLTs", "administrative assistance", prompt payment, "allow clinicians more discretion/support in clinical decision making."

Associations (mltq15) –78 answered:

The majority mentioned additional publicity and outreach (21) sometimes specifically mentioning outreach to the MLT professional associations (15), to MLT schools (4), and through the Department of Health (DOH) renewal mailings or the DOH Bulletin (3).

Several mentioned therapists' Facebook (FB) pages.

- "Advertise through therapist list serves and Facebook pages (Greater Seattle Therapists FB page)."
- "Advertise the program at schools and at community mental health centers and at King County's required trainings."

Others mentioned better or prompt payment (18), offering training (12), and decreasing L&I bureaucracy or other process improvements (9).

What is stopping you from increasing the number of workers in this pilot that you treat?

Only those who said they receive the right number or too many referrals were asked this question.

Pilot Participants – 28 answered:

- Caseload is full (16)
- L&I payment issues (4)
- L&I administrative challenges or requirements (4)
- Nothing, willing to see more workers (4)

Other Questions Asked of Only One Group

Pilot Dropouts. The four MLTs who had withdrawn from the pilot each had their own reasons which included no time in their practice, too few referrals, payment issues, and paperwork. More detail can be seen in the table below.

Table 28. Pilot project dropouts participation

	According to L&I's records you withdrew from the pilot. Why? *(doQ4)*	**What might incentivize you to rejoin or participate in the pilot?** *(doQ6)*
MLT 1	"Too few referrals"	"Self- direct contract instead of through the group"
MLT 2	"I was doing this work on top of a full-time job, and needed to cut back my hours due to being too busy."	"I continue to work a busy full-time position as a therapist, so am not interested in working more on top of that. If I were ever needing more work hours, I would consider this as an option. I really enjoyed working with the clients and physician's office."
MLT 3	"Too much paperwork and not being reimbursed for client no shows."	"Less paperwork. In person sessions. Credit card on file."
MLT 4	"Issues with clients not showing up for sessions and not being paid in a timely fashion."	"I would not rejoin. Too busy."

Training Only. The MLTs who completed the training but didn't take the steps to join the pilot were asked why they didn't. Comments were received from all 11 individuals who completed the survey.

- The most frequently mentioned reason was administrative challenges with the application process (4). For example, "I filled out ALL the paperwork on the website and mailed it in per their instructions. They sent it all back to me saying it was the wrong paperwork! How?? I'd gotten it off their website! A friend convinced me to try again, so I had to do EVERYTHING again. This time when I got to the training module which I had to repeat, the link was broken???? I'm just deeply frustrated with the whole process."

- Two MLTs mentioned application challenges on their employer's side. One of them couldn't get the employer to sign off because of the pandemic-related chaos. Another said "Since I am the only one that is trained in my company, it was not economically feasible for them to go through the machinations to set up a medical billing side."

- Two MLTs didn't meet pilot criteria. One had their application rejected because associates weren't being accepted. Another said "I only provide Telehealth services. When I got done with the training they could not Credential me because, "Unfortunately we are unable to accommodate a provider without a physical/street address at this time, a PO Box is not sufficient to meet our policy." And I did not feel comfortable putting my personal home address for clients to see."

For the remaining three who did not join the pilot, reasons follow.

- "I specialize in biofeedback treatment and the MLT program did not include coverage for this type of treatment."

- "I did not receive any clients with that payment source."

- "I was worried about the oversight from the program trying to have too much influence over my therapeutic relationship with the clients. It seemed to want too much involvement with communication and reporting when the therapeutic relationship needs to remain confidential. I hundred percent agree with working to get the clients back into their job but not because the program is set up for us to do so."

Association Members. The five MLTs who responded to the association survey and said they had heard of the pilot before the survey were asked what had stopped them from participating in this pilot. (MLTq4) There were a diversity of responses.

- "I don't treat adults mostly."
- "Basically, I failed their procedures exam twice. I have two graduate degrees and if I can't pass that why would I waste my time."
- "I have been in the process of moving across the USA."
- "Payments are too low according to my information."
- "Nothing"

Chapter 2: Online Survey of L&I Claim Managers

This chapter reports on the online survey L&I conducted between January and March 2022 of claim managers about the MLT pilot project. It is included with the UW work so that all survey data will be together.

The survey questions can be found in Appendix 5 and the open-ended responses in Appendix 5B.

Survey Eligibility, Recruitment and Responses

Survey invitations were sent to claims supervisors who were asked to send it on to their staff who were eligible to have claims with MLTs. It is unknown how many claim managers received the invitation email. The survey was opened 74 times but only 24 (32%) surveys had any questions answered.

The first question asked for the claim unit of the claim manager (Table 1). Sixteen units were represented in 23 surveys. This field was left blank on one survey.

Table 1. Numbers of responses by claim unit.

Unit	#		Unit	#
4	3		L	1
5	2		M	1
6	1		N	1
8	2		O	1
A	1		V	2
C	1		W	1
H	1		Y	2
K	2		Z	1

Survey Results

The next question asked "**Are you aware of claims you've had that received master's level therapist services?**" to which the majority said "yes."

Table 2. Awareness of claims with MLT services

Response	Number of surveys	% of surveys with answers	% opened surveys
Yes	16	67%	22%
No	2	8%	3%
I'm unsure	6	25%	8%
Total	24		33%

Those 16 respondents represented 12 claim units as can be seen in Table 3.

Table 3. Awareness of MLT services by Claim Unit

Claim Unit	Surveys N	Aware N
4	3	2
5	2	1
6	1	1
8	2	1
A	1	1
C	1	0
H	1	0
K	2	1
L	1	1
M	1	1
N	1	1
O	1	1
V	2	2
W	1	0
Y	2	2
Z	1	0
Blank	1	1
16	24	16

Only the 16 respondents who said "yes" were offered further questions. The eight surveys whose respondents said "no" or "unsure" ended after that question.

A majority of respondents (69%) said 50% or less of providers were aware of the pilot (Table 4). Another 25% of respondents said up to 75% of providers were aware of the pilot.

Table 4. In your experience, what percentage of providers in your area are aware of the MLT pilot?

	N	%
0-25%	8	50%
26 - 50%	3	19%
51 - 75%	4	25%
76 - 100%	1	6%

Although the majority of respondents (69%) said there were no barriers to attending providers making MLT referrals, this response should be interpreted with caution. We would expect this number to be lower based on responses to the prior question about provider awareness of the pilot. Only respondents who said "yes" there were barriers were able to go on to the drop-down list to select type of barriers. Since almost all respondents said less than 100% of providers were aware of the pilot, one

would assume a majority of them would have said "yes" there were barriers if they knew awareness of the option to refer to MLTs was considered a barrier.

Table 5. In your experience, have there been any barriers to attending providers (APs) making referrals to an MLT?

	N	%
No	11	69%
Yes	5	31%

Table 6. If Yes, what were they? (Select all that apply)

	N	%
AP not aware of the option of referring to an MLT	4	25%
AP not recognizing a problem that could be addressed by an MLT	2	13%
No MLT available within a reasonable distance	2	13%
AP knowledge of available MLTs	1	6%
AP willingness to refer to an MLT	1	6%
Other: "Very few MLTs are bilingual or willing to work with an interpreter"	1	6%

Although a majority of respondents (88%) said they had not seen barriers to MLT care for workers (Table 7), the two who said they had seen barriers listed several reasons (Table 8).

Table 7. After the referral, in your experience, have there been barriers to a worker receiving care from an MLT?

	N	**%**
No	14	88%
Yes	2	13%

Table 8. If yes, what were they? (Select all that apply)

	N	%
Transportation including distance:	1	50%
Tech issues if only telehealth is available	1	50%
No MLT with available time	1	50%
Worker's willingness to see the MLT	0	
Worker's failure to attend sessions after a referral	0	
Delays in Authorization or Utilization Review	0	
Worker didn't like the MLT or the MLT's approach	1	50%
Other - Write In - AP unwilling to send request	1	50%
Other - Write In - Language barriers	1	50%

Respondents said that access to behavioral health interventions had improved (75%) or was unchanged (25%) (Table 8). No respondent reported that access worsened.

Table 9. How has the MLT pilot program changed worker access to behavioral health interventions?

	N	%
Improved	12	75%
Unchanged	4	25%
Worsened	0	

A large proportion of respondents (88%) said there had been no change in the number of mental health diagnoses they had seen contended in their caseload with MLT services (Table 10). However, 62% said the claims with MLT care don't move forward any faster although some respondents (38%) had seen claims avoid delays (Table 11).

Table 10. Have you seen a change in the number of mental health diagnoses contended in your caseload with MLT services?

	N	%
Increase	2	13%
No Change	14	88%
Decrease	0	

Among the small number (2) who reported an increase, they were asked why:

If increase, why?

- "There are 2 MLT providers I see most often in my claims. One of them provides mental health diagnoses on most of the claims, especially if there is an attorney involved."
- "MLT likes to diagnose everything claim related or not."

Table 11. For those workers who participated in the MLT pilot, did their claims move forward with fewer delays or barriers?

	N	**%**
Yes	5	38%
No	8	62%

"Yes" explanations:

- "There are fewer delays, however It appears when an attorney is involved they push for mental health anyways which causes the barrier/delay"
- "Yes, as they can receive help when there is no formal diagnosis"
- "For the most part. I think there needs to be provider bulletins brought back as I am experiencing lots of new doctors unaware of how to navigate LNI and they are unaware of the MLT program"
- "Avoided a MH [mental health] condition on claim"
- "I've seen this prevent mental health contention later on"

"No" explanations:

- "It seems to be about the same"
- "Not seeing much of a change"
- "You have to want to get better for psych to have any chance of success…"
- "Nature of my caseload is that the MLT's I am seeing are actually treating under a diagnosis not just BHI. I have seen on other claims that BHI has removed some barriers but they are not my claims specifically."
- "Gone from able to work to completely disabled"
- "I find the mental health conditions are still contended"
- "Usually worker formally contends MH [mental health] anyways after MLT services are done"
- "It depends on whether or not the MLT provider was formerly a vocational counselor."

A majority of respondents (75%) said that MLT-provided behavioral health services are the same or better than those provided by psychologists/ psychiatrists or psychiatric advanced registered nurse practitioners (ARNPs) (Table 12).

Table 12. How do behavioral health services compare when provided by MLTs as opposed to Psychologists/Psychiatrists/Psych ARNPs?

	N	%
Better	4	33%
Same	5	42%
Worse	1	8%
Other	2	17%

"Other" comments:

- "Sometimes worse and sometimes better. It all depends on the rest of the issues in a claim, i.e. was the MLT a former vocational counselor? Does the IW have an attorney?"
- "There is very little information in most MLT or even BHI [behavioral health intervention] reports (usually a few sentences) & often there are no notes at all to monitor progress."

Chapter 3: Worker Surveys

This chapter reports on the surveys of workers completed between April 7 and September 14, 2022.

Survey Eligibility

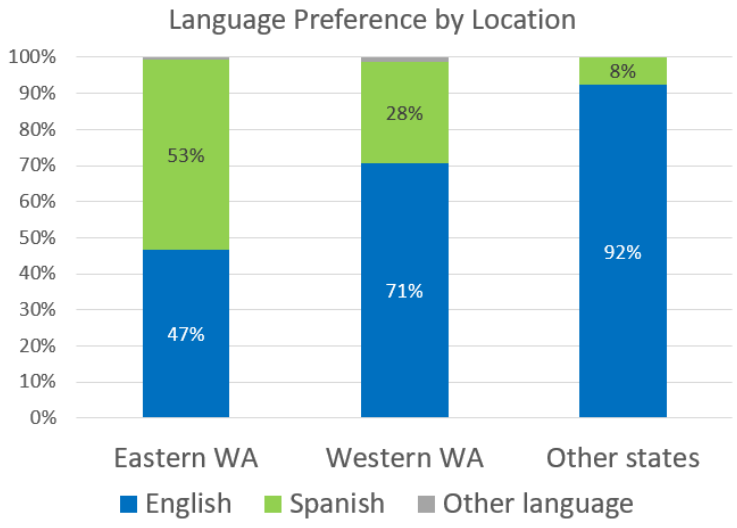
At the end of January 2022, L&I provided contact information to the UW team for workers who had an accepted state fund claim with at least one bill (paid or unpaid) with an MLT provider in 2020 or 2021 (regardless of when the claim was filed). We were not able to obtain self-insured claim information. MLT providers were identified using Provider Type 77 and Specialty codes H7, H8, or H9.

Table 1. *Worker preferred language*

	Claims (N=994)	Workers (N=990)	% of Workers
Spanish	314	312	32%
English	670	668	67%
Other languages	10	10	1%
Russian	2	2	<1%
Arabic	2	2	<1%
Thai	1	1	<1%
Punjabi	1	1	<1%
Korean	1	1	<1%
Romanian	1	1	<1%
Farsi	2	2	<1%

The worker surveys were available in English (Appendix 6) and Spanish (Appendix 7). Because of the small numbers of workers preferring languages other than Spanish or English, the ten workers who had indicated a preference other than those two languages were not invited to participate. Figure 1 shows language preference by location (Eastern Washington, Western Washington, or another state).

Figure 1.



It should be noted that the English preference group is a default category including everyone who hasn't indicated a different language preference to L&I. Consequently, it's possible that those sent an invitation in English may not be able to read it.

The majority of workers had seen only one MLT, however 3% in the English language group and 6% in the Spanish language group had bills from more than one MLT.

Translation of Questions and Worker Materials

Staff at L&I in the Language Access group in Insurance Services translated the worker survey and recruitment materials into Spanish for this project. The Spanish version of the survey can be found in Appendix 7. Some minor additional translation needs and questions were handled by a bilingual PhD student. She also responded to Spanish voice mails that were left on the study phone and conducted the survey by telephone when the worker reported they didn't have access to a computer. After surveys were completed the student reviewed the Google translation of the open-ended question responses and made corrections as needed.

Survey Recruitment

A total of 980 workers who preferred Spanish or English were sent an introductory letter invitation to participate in the online survey. Of these, 312 workers were sent the Spanish version of the introductory letter invitation to complete the Spanish version of the online survey. All survey respondents were eligible to receive a $50 check as an incentive to complete the survey.

The 78 Eastern Washington English recruitment letters were sent out April 6, 2022. The 88 Eastern Washington Spanish recruitment letters were mailed May 3rd. The 221 Western Washington Spanish letters and 3 other states' Spanish letters were mailed May 11th, and the 554 Western Washington English letters and 36 other states' letters were mailed June 25th.

Table 2. *Worker survey recruitment numbers*

	English	Spanish
Number of Workers	668	312
Bad addresses	-17	-10
Died	-4	0
Assume received invitation	647	302

Two reminder letters were sent to those who had not yet participated. The goal was to mail letters approximately every 2-3 weeks, however that was not always feasible due to staffing. A longer period between mailings had the advantage of allowing undeliverable letters to return which regularly took 4 weeks. The worker surveys were originally planned to be kept open for 8 weeks but that was extended for 2 reasons: (1) the English surveys of the eastern and western parts of the state were started 2 months apart partly because of the numbers of mailings involved and (2) returned letters led to suggested better addresses which were then re-mailed. The surveys needed to stay open to allow the latest mailings time to reach the worker. Consequently, the Eastern Washington English survey was open 5.5 months and the western Washington survey 3.5 months. The Spanish survey was open 4.5 months

in the eastern part of the state and 4.3 months on the western part of the state. [from survey dates 2023-0111 in recruitment folder]

Deaths came to our attention either because a family member notified the study group or from L&I records.

Bad addresses did not differ significantly between Eastern Washington (3.6%) and western Washington (2.5%) (p = 0.42). They also did not differ significantly between those with English preference (2.5%) and those preferring Spanish language (3.2*%)* (p = 0.56).

Data Collection and Management

Study data were collected and managed using REDCap tools hosted at the University of Washington via Institute of Translational Health Science (ITHS) grant support (UL1 TR002319, KL2 TR002317, and TL1 TR002318 from NCATS/NIH).[1,2] REDCap is a secure, web-based software platform designed to support data capture for research studies, providing 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for data integration and interoperability with external sources.

Response Rates

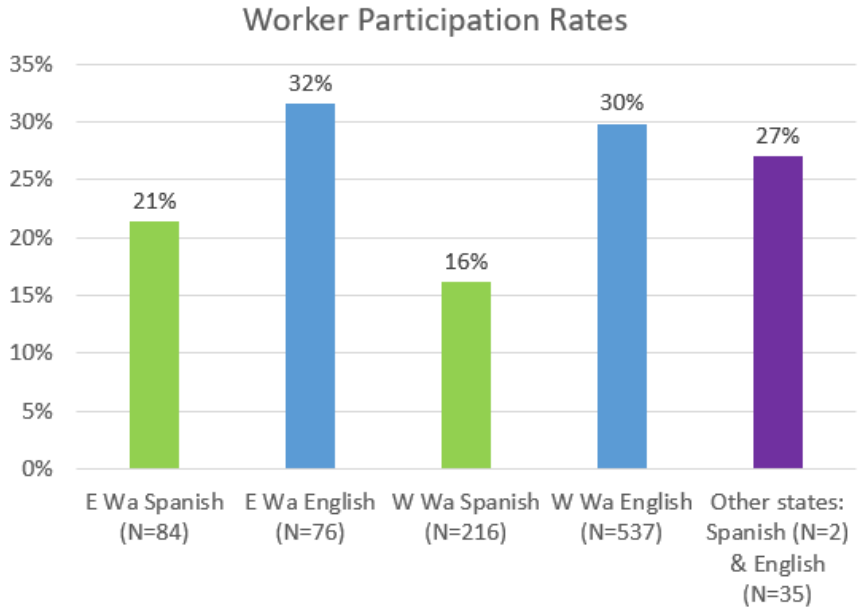
Overall, 254 worker surveys were started: 200 English and 54 Spanish (Table 3). A few workers who did not have internet access or had difficulty logging into the survey called the study office and were offered the option to complete the survey by phone. Ten workers completed the survey by telephone: 1 English and 9 Spanish. Four workers completed more than one survey, one of whom completed the survey four times. The results from the first complete survey from each worker were used in the analysis.

Table 3. *Response numbers by language preference*

	English	Spanish
Assume received invitation	647	302
Surveys started	200	54
Duplicate surveys	-7	0
Total number of surveys	193	54
Response rate	30%	18%

The Eastern Washington response rates were slightly higher than the Western Washington response rates for both English and Spanish surveys (Figure 2).

Figure 2.



Some Workers Answered the Questions about their Physical Therapist (PT), not the MLT

When reviewing the open-ended question responses, we noticed that some workers answered the questions about their physical therapist, rather than their MLT. Examples follow.

What was helpful?

- "Massage, splints, paraffin wax"
- "They also helped with the stiffness and swelling."
- "Helpful with releasing pain. How to deal with pain, in the future. Learning different kinds of stretch exercises and continue to do stretches in daily life routine."
- "Did not understand my medical condition and did movements and procedures that significantly worsened my condition."

What was helpful? "To get me moving helping my legs get strength"

The invitation letter mentioned the name(s) of the MLT(s) the worker had seen, since in some cases it had been a number of months since the visits and the worker might have forgotten which of their providers was the MLT. There had been discussion with L&I staff about whether to refer to the MLT as "therapist" or "counselor" in the survey. "Therapist" was chosen. Future surveys may want to include additional information on the role of the MLT and/or choose the term "counselor" to avoid confusion with physical therapists.

Because of this, all open-ended comments were classified as "MLT," "PT," "possibly PT," or "can't tell." An example of a "can't tell" comment is "He was nice." Two team members (TSW and DE) reviewed and classified the comments that were "PT" or "possibly PT." Comments that were determined to be about PTs were excluded from the response analyses.

In addition, 5 surveys that only had responses to the consent questions had no information to contribute to the response analyses so are removed in the following table.

Table 4*. Survey completion numbers by language*.

	English	Spanish
Surveys (from Table 3 above)	193	54
Surveys with only consent questions completed	-1	-4
Removed due to PT comment	-14	-4
	178	46

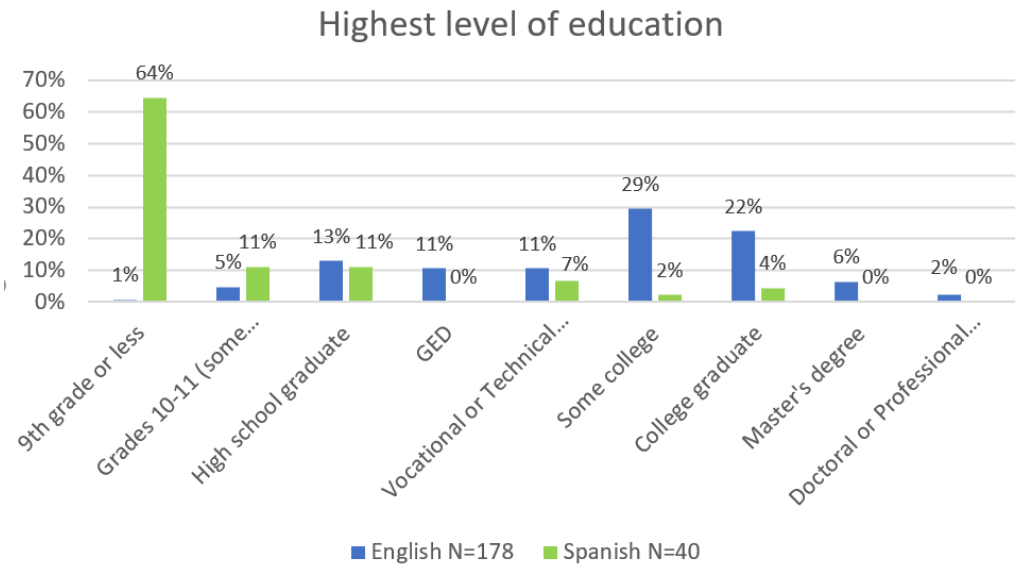
Numbers in the tables below may vary if a question was skipped or a worker quit before the last question.

Demographics

Demographic questions were asked at the end of the online survey. The numbers may be lower than the total number of surveys started since some workers stopped before or during the demographic questions.

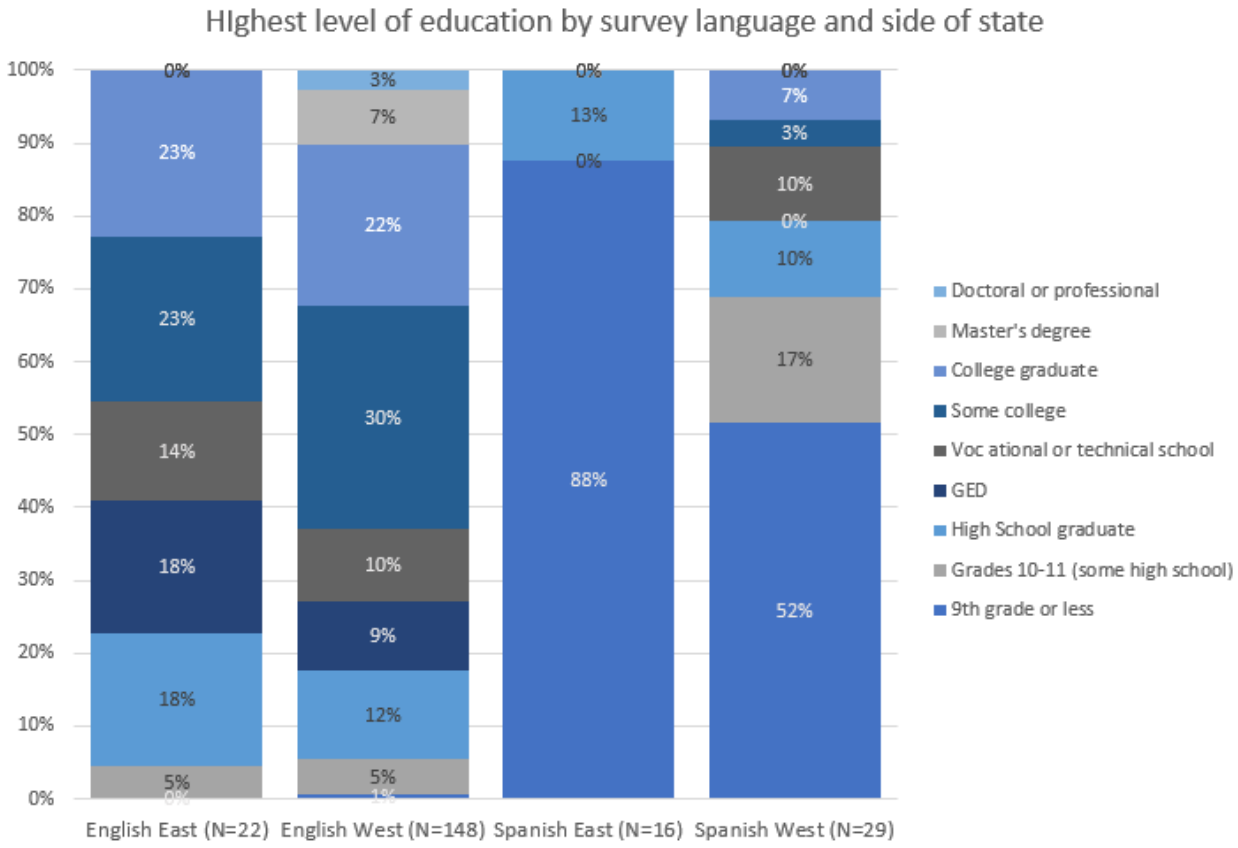
Education level of the workers completing the English survey was higher than those completing the Spanish survey (Figure 3). A majority of those completing the Spanish surveys had completed the 9th grade or less whereas a majority of the English surveys were completed by workers with at least some college education.

Figure 3.



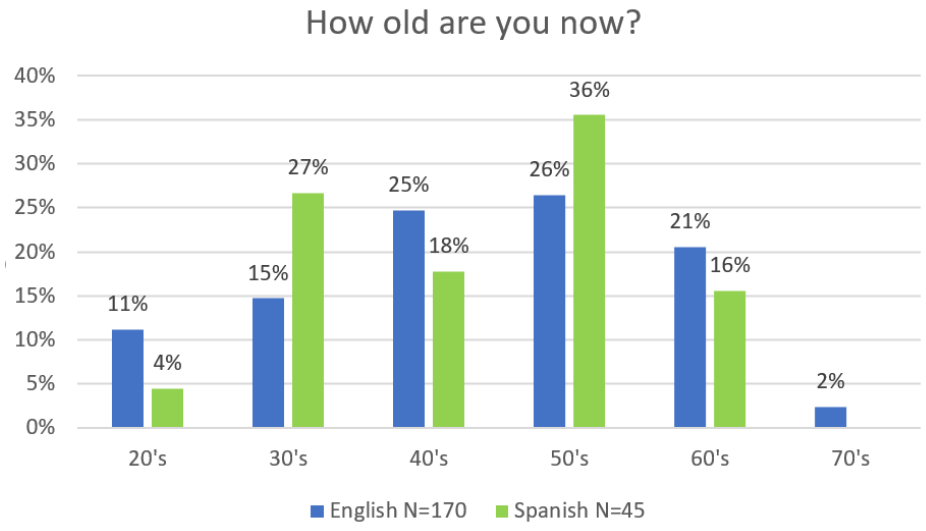
When looked at by side of state and survey language, those on the western side of the state had more education regardless of the language of the survey completed (Figure 4). (Lower education levels are shown at the bottom and higher education at the top of the figure.)

Figure 4.



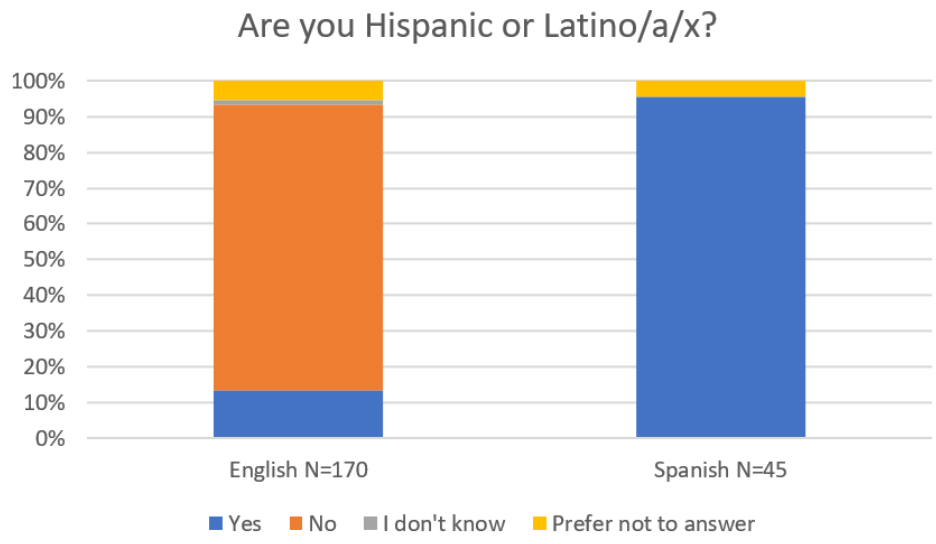
The age distribution was similar for those completing the surveys in English and Spanish (Figure 5).

Figure 5.



As expected, most (over 90%) of the workers completing the Spanish survey reported they were Hispanic or Latino/a/x, in contrast to 10% of those completing the English survey (Figure 6).

Figure 6.



Similarly, the majority (66%) of those completing the English survey reported they were white versus 22% of those completing the Spanish survey (Figure 7). A majority of those completing the Spanish surveys selected the "Other" race category. The write-ins for those "other" categories can be seen in Table 5 below. Most of those completing the Spanish survey reported Mexican or Hispanic for their race.

Figure 7.

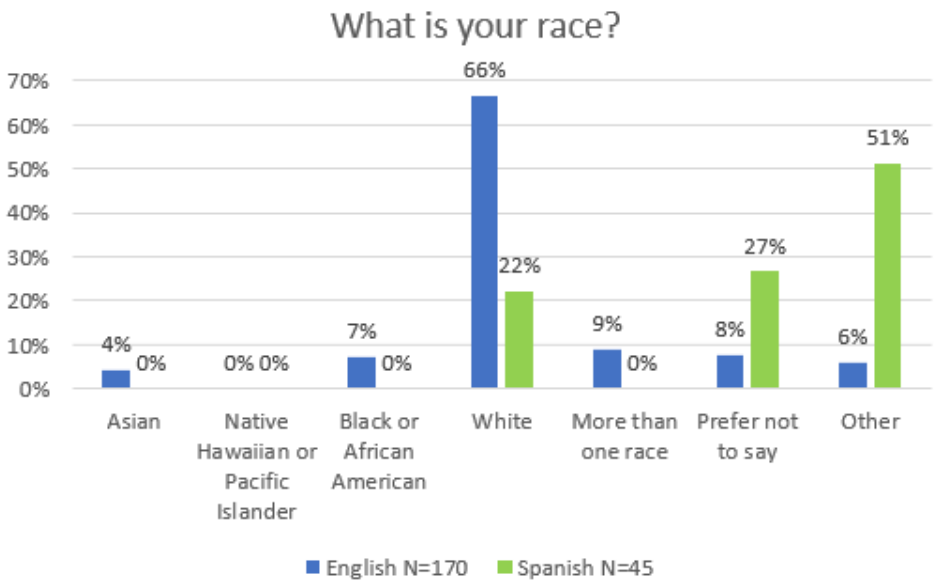
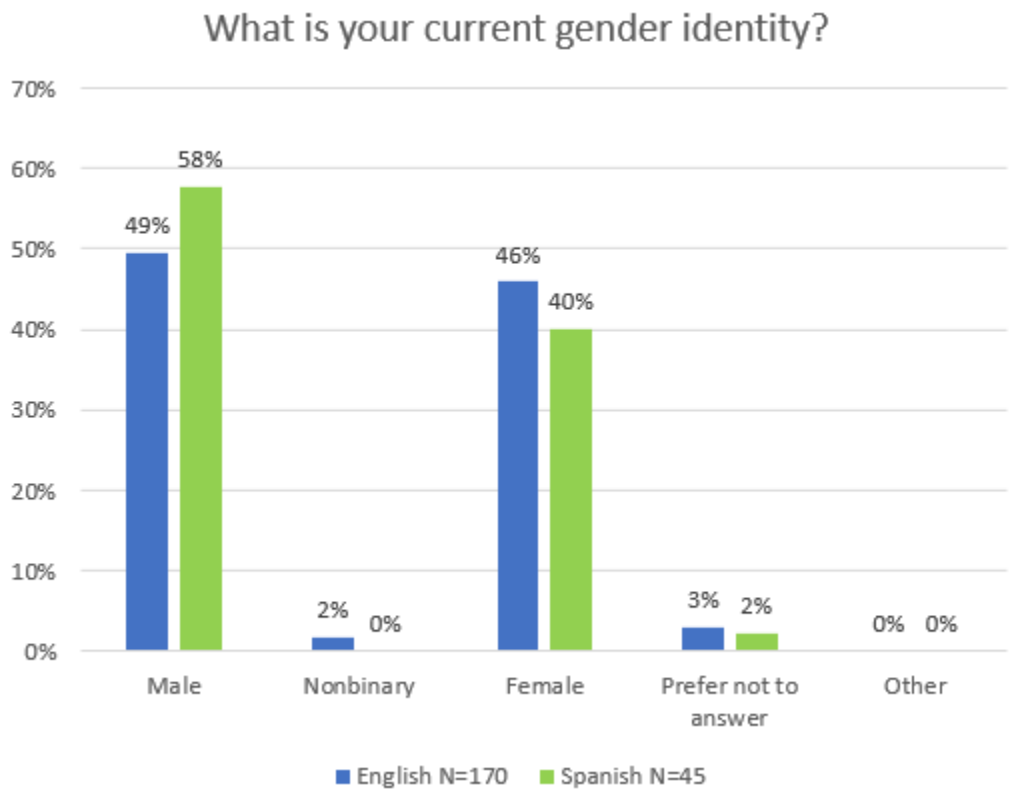


Table 5. *Other race responses*

	English surveys N=10	Spanish surveys N=23
Blank	30%	17%
Mexicana/ Mexicano		39%
Ispano / Hispano / Latino hispano		39%
Mestizo		4%
Mexican American	10%	
Salvadorian	10%	
East Indian	10%	
Eastern European	10%	
Alaskan native	10%	
No idea how to answer	10%	
Unknown	10%	

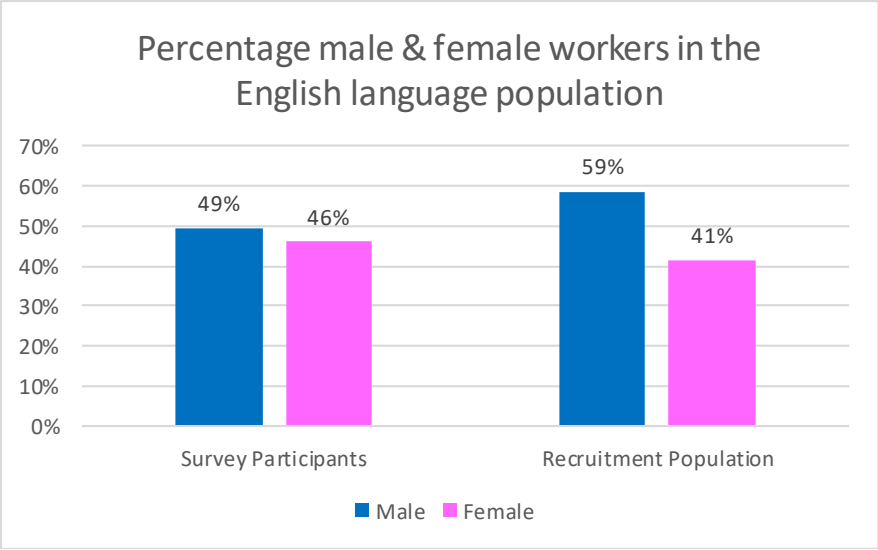
Both surveys had more men than women completing them (Figure 8). The Spanish survey had 58% male and the English survey had 49%.

Figure 8.



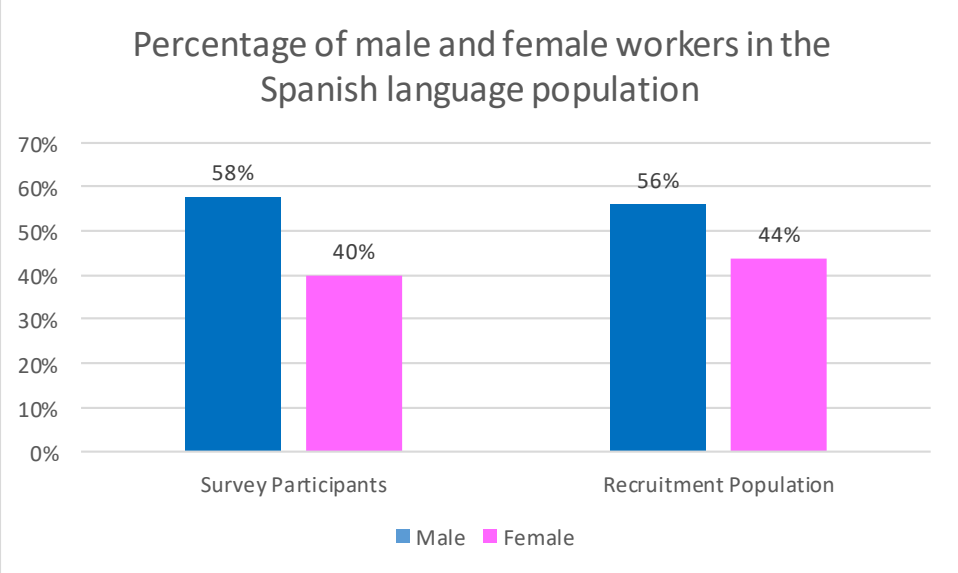
In the English language population males were a smaller percentage of the survey participants (49%) than of the recruitment population (59%) (Figure 9). In contrast, females participated at a higher percentage (46%) than they are represented in the recruitment population (41%).

Figure 9.



In the Spanish language populations males participated at a slightly higher percentage (58%) than their representation in the recruitment population (56%) (Figure 10). In contrast, the Spanish language females participated at a lower percentage (40%) than they were represented in the recruitment population.

Figure 10.



Survey Results

Open-Ended Questions

Open-ended questions were reviewed by two team members, TSW and AE, who grouped the responses into categories. The categorizations were then compared and when there were disagreements, they were reviewed and reconciled. The complete comments can be found Appendix 6B and 7B (English translation of the Spanish survey open-ended comments. Appendix 7C has the original Spanish open-ended responses.

Connecting to a Therapist

The majority (69%) of those completing the English survey were referred to a specific MLT by their attending provider (Table 6). Of those completing the Spanish surveys, 41% had their MLT chosen by their attending provider. A much higher percentage of those completing the Spanish survey (38%) located their own therapist as compared to those completing the English survey (6%).

Table 6. After your attending provider (AP) chose to send you to a therapist, how was the therapist chosen?

	English N=178	Spanish N=46
My AP gave me the name of the therapist. Then I contacted the therapist to make the appointment.	20%	3%
My AP told me that a therapist would call me to schedule the appointment.	49%	38%
I used the website "Find a Doc" to locate an MLT in my area.	6%	38%
I don't know	10%	18%
Other	15%	5%

The "other" comments usually described which other professionals were involved in choosing an MLT (Table 7). Of those who chose the "other" response, most of those completing the English survey mentioned the involvement of a vocational counselor in the process.

Table 7. Other comments

	English N=25	Spanish N=6
Vocational rehabilitation counselor	11	2
Attorney	2	
Claim manager or unspecified L&I staff	3	1
Interpreter		1
Worker chose the MLT	3	1
Other unrelated comment	6	
Don't remember		1

When asked if they had difficulty finding a therapist in their area, 40% of the respondents to the English survey were neutral, with 41% saying it was easy or very easy (Figure 11). Even more respondents to the Spanish survey said it was easy or very easy (76%), with fewer saying they were neutral (11%).

Figure 11.

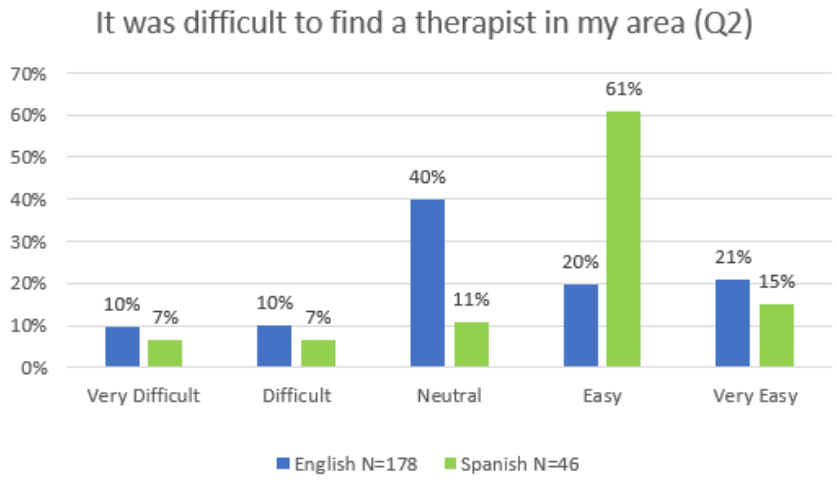
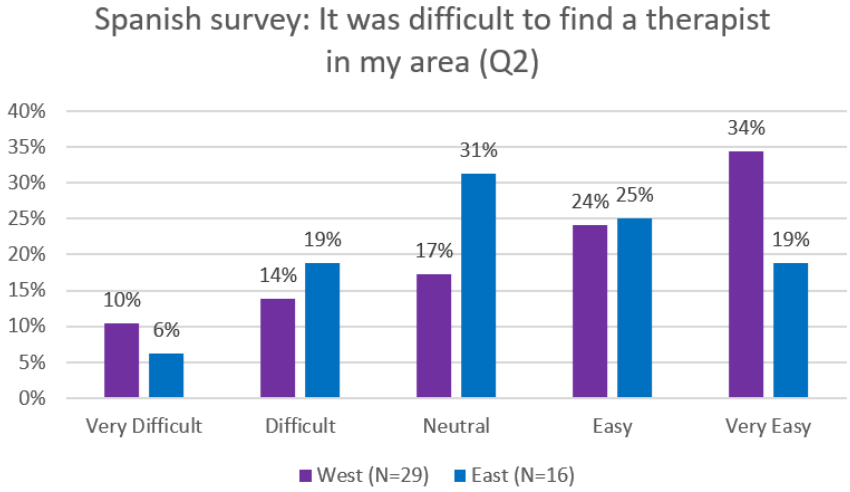


Figure 12.



Results for the question about difficulty in finding a therapist, broken out by eastern Washington, western Washington, and other states are shown in Figure 12 for Spanish surveys, Figure 13 for English surveys, and Figure 14 for both surveys combined.

Figure 13.

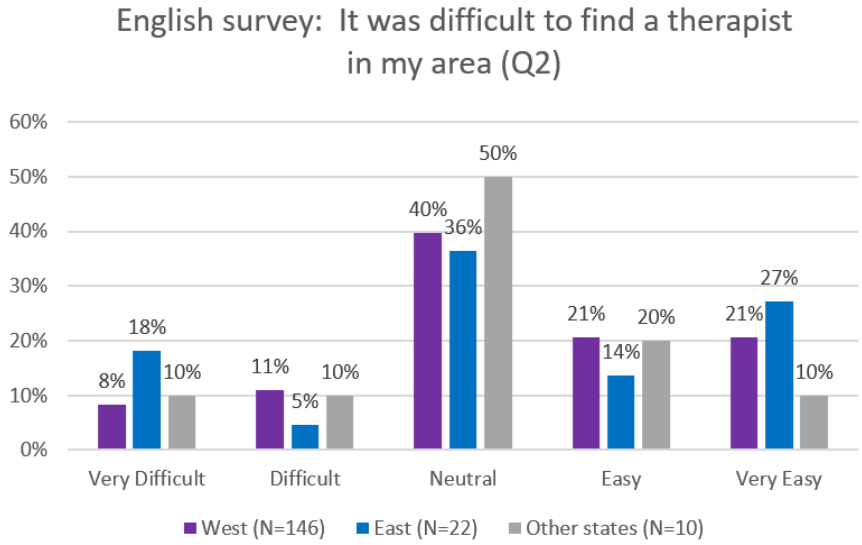
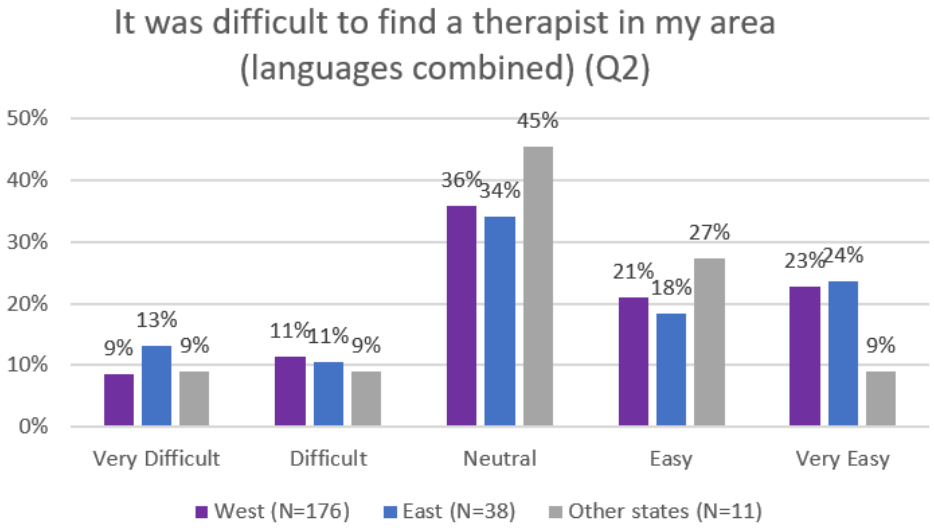


Figure 14.



Workers were asked about length of time until the appointment with the MLT (Table 8). More English survey respondents (55%) were able to have appointments within 2 weeks than those completing the Spanish survey (35%).

Table 8. How long was it from when your AP decided to have you see the therapist until your first visit?

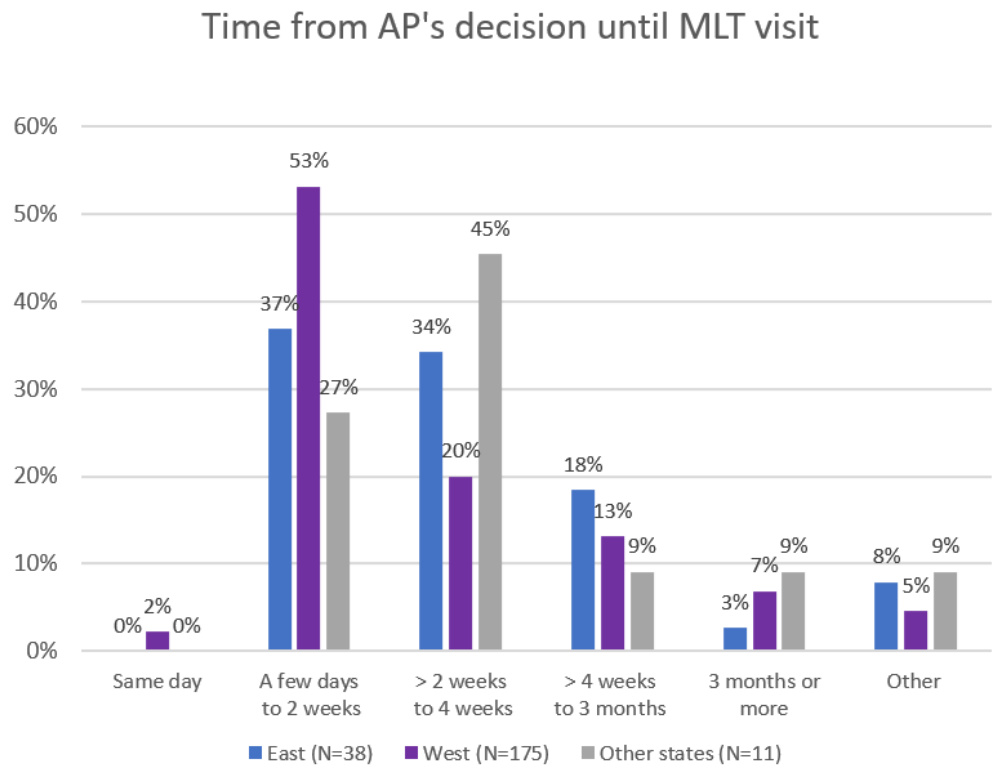
	English N=178	Spanish N=46
Same day	2%	2%
A few days to 2 weeks	53%	33%
More than 2 weeks up to 4 weeks	22%	33%
More than 4 weeks up to 3 months	14%	15%
3 months or more	4%	4%
Other	6%	13%

Other responses:

- The majority of those who included a comment said they didn't know or remember.
- Four workers said that their attending physician wasn't involved at all.

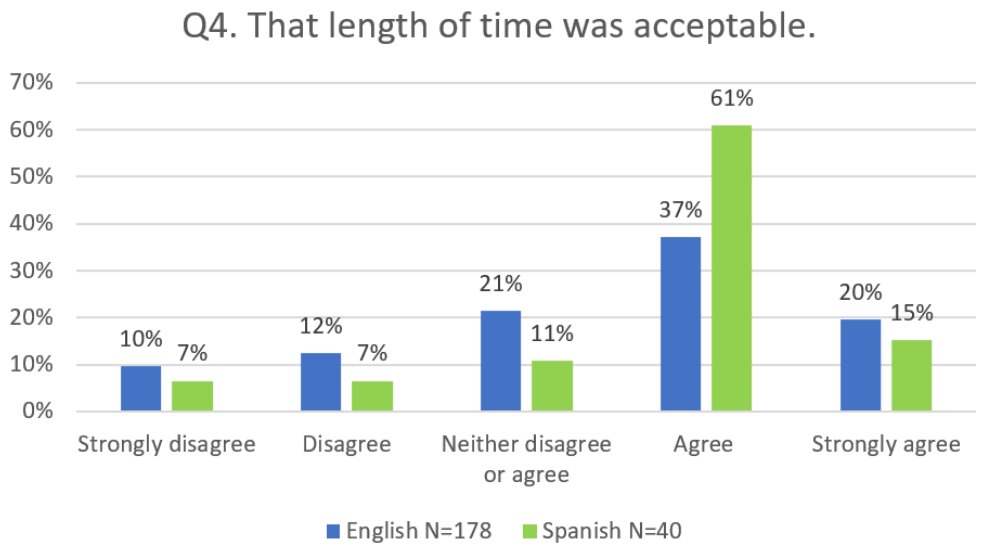
When broken out by the side of the state, 55% of those on the western side of the state had their appointments within 2 weeks compared to 37% on the eastern side of the state (Figure 15).

Figure 15.



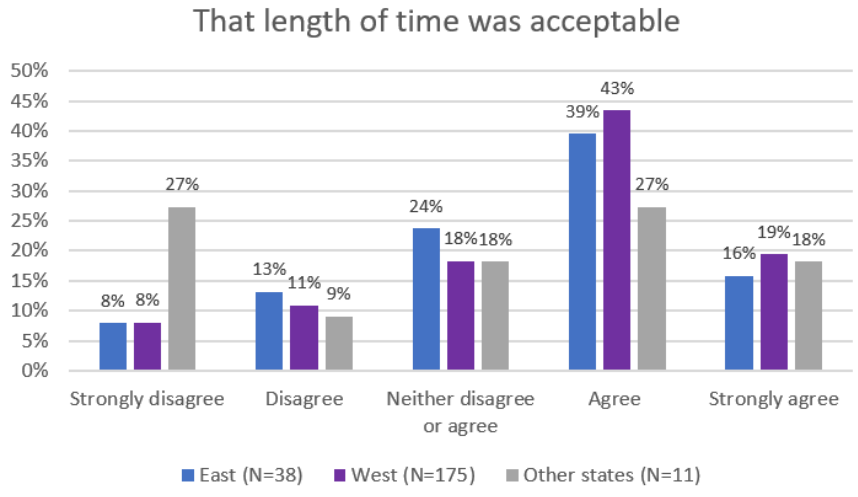
When looked at by language, a higher percentage (76%) of those completing the Spanish survey agreed that the time to the first appointment was acceptable compared with those completing the English survey (57%) (Figure 16).

Figure 16.



The percentage (62%) that found the length of time acceptable on the western side of the state exactly matched those that had appointments within 2 weeks (Figure 17). However, although 37% of the respondents from the eastern side of the state had appointments within 2 weeks, 55% of the respondents said the time to appointment was acceptable.

Figure 17.



Types of Visits

Most (63%) of those completing the English survey did not see the therapist in person (Table 9). Most of these MLT visits were in 2020 and 2021 during the height of the pandemic when in-person visits might not have been an option. However, the majority (52%) of those completing the Spanish survey did see the therapist in person at least once.

Table 9. Did you ever see the therapist(s) in person?

	English N=177	Spanish N=46
Yes	37%	52%
No	63%	48%

When looked at by geographic side of the state, those living on the west side of the state and completing the English survey were least likely to see the MLT in person (24%) (Table 10). Those living on the east side of the state and completing the Spanish survey were most likely to see the MLT in person (69%).

Table 10. Percent of Workers with In-Person Visits by side of state.

% in person	English surveys	Spanish surveys
Eastern Washington	54%	69%
Western Washington	24%	43%

Most of those who saw the therapist in person traveled 15 miles or less: English survey 54% and Spanish survey (71%) (Table 11). The one person that selected "other" said they traveled 50 miles one way which is farther than they travel to see other health care providers. They lived on the eastern side of the state.

Table 11. How far did you travel to see the therapist(s) (one-way)? [asked of those who saw the therapist in person]

	English N=57	Spanish N=24
1-15 miles	54%	71%
15-30 miles	24%	17%
> 30 miles	19%	13%
Other	3%	0%

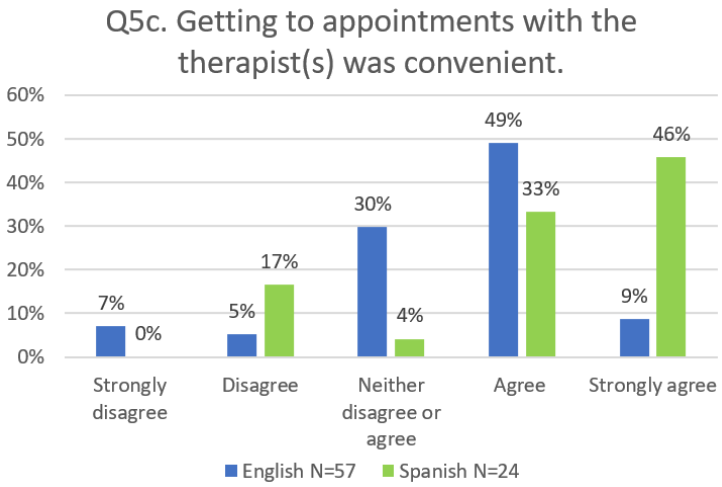
Half or more (71%) of those who saw an MLT in person said they traveled about the same distance as they travel to see other health care providers (Table 12). The rest were evenly split between saying they traveled farther or shorter than to see other health care providers.

Table 12. The distance I traveled was ___

	English N=57	Spanish N=24
Farther than I travel to see other health care providers	26%	13%
About the same distance as I travel to see other health care providers	50%	71%
Shorter than I travel to see other health care providers	24%	17%

A much higher percentage of those completing the Spanish survey (79% vs. 58%) said that getting to appointments was convenient (Figure 18).

Figure 18. Of those who saw the therapist in person:



More of those completing the Spanish survey on the eastern side of the state found getting to appointments inconvenient than those on the western side of the state (Figure 19) while those completing the English survey found the convenience approximately the same whether on the eastern or western side of the state (62% vs. 56%) (Figure 20).

Figure 19.

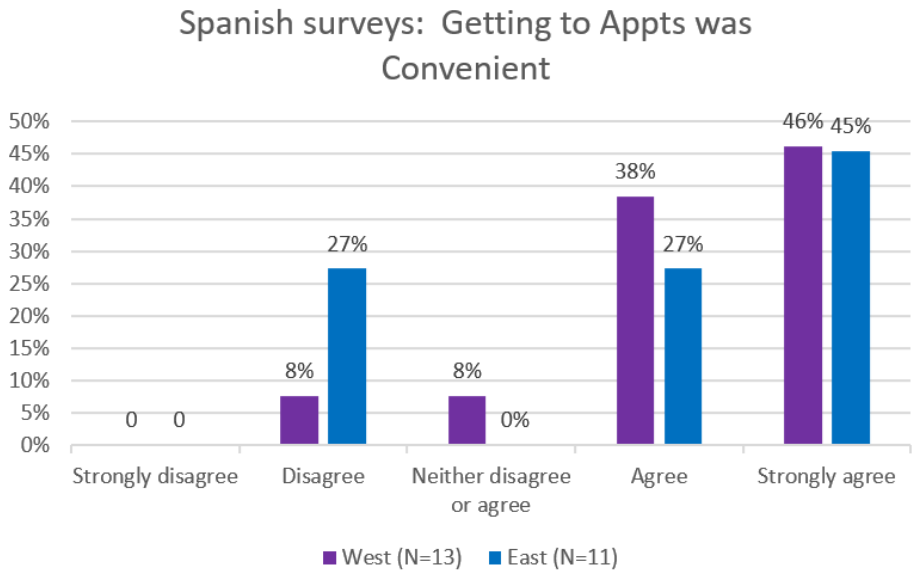
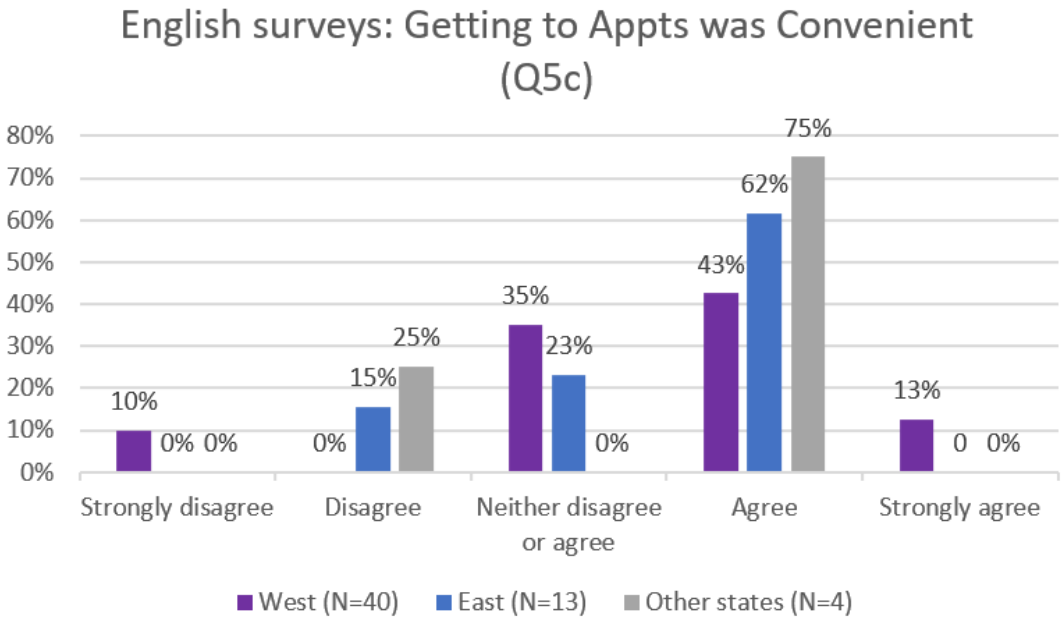
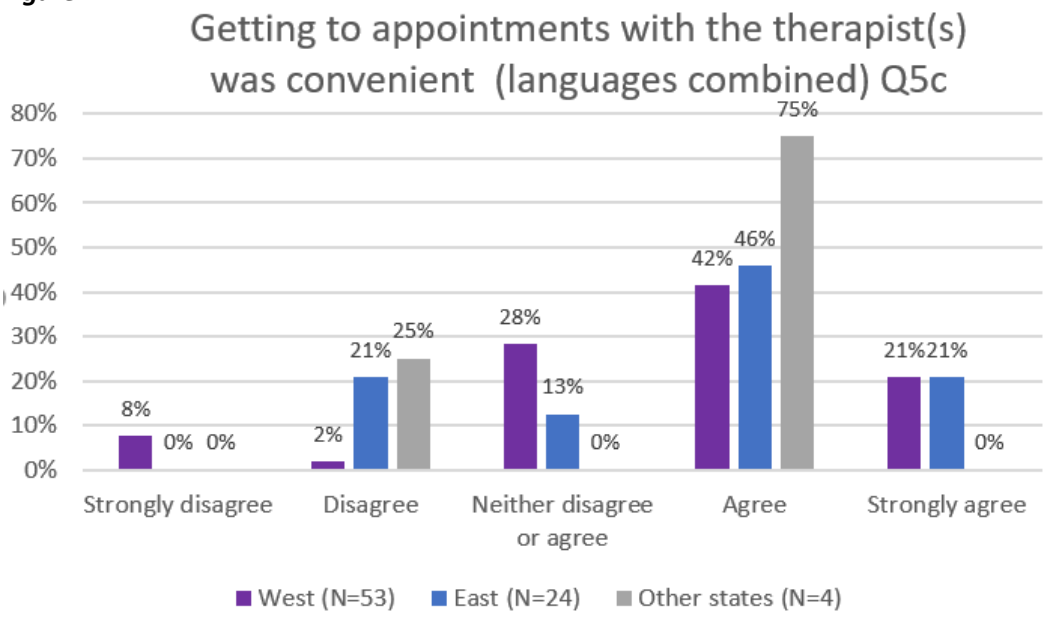


Figure 20.



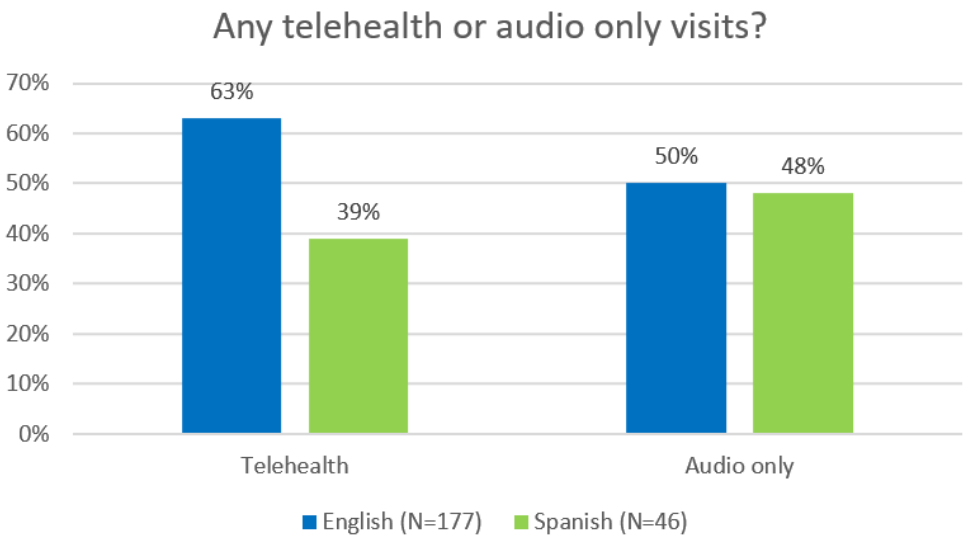
When all languages were combined, the eastern side of the state had a higher percentage of workers that said travel was inconvenient (21% vs. 10%) (Figure 21).

Figure 21.



Two questions asked whether the worker had any telehealth or audio only (e.g., telephone or telehealth without video) visits. A majority (63%) of the English survey respondents had at least one telehealth visit in contrast to the 39% of the Spanish survey respondents (Figure 22). These results are consistent with the percent of workers who saw an MLT in person (see Table 10). About half of the respondents had had an audio-only visit.

Figure 22. Did you use telehealth (video) for any visits with the therapist(s)? Did you have any visits with the therapist(s) by audio /telephone?



There were many more workers on the west side of the state that had both audio and telehealth visits, all 3 types of visits (in-person (IP), telehealth, and audio), and telehealth-only visits compared to the eastern side (Figure 23). The eastern side of the state had more in-person and audio (yellow) and only in-person visits (medium blue) than the western side. Figure 24 further breaks down the types of visits by language of the survey.

Figure 23.

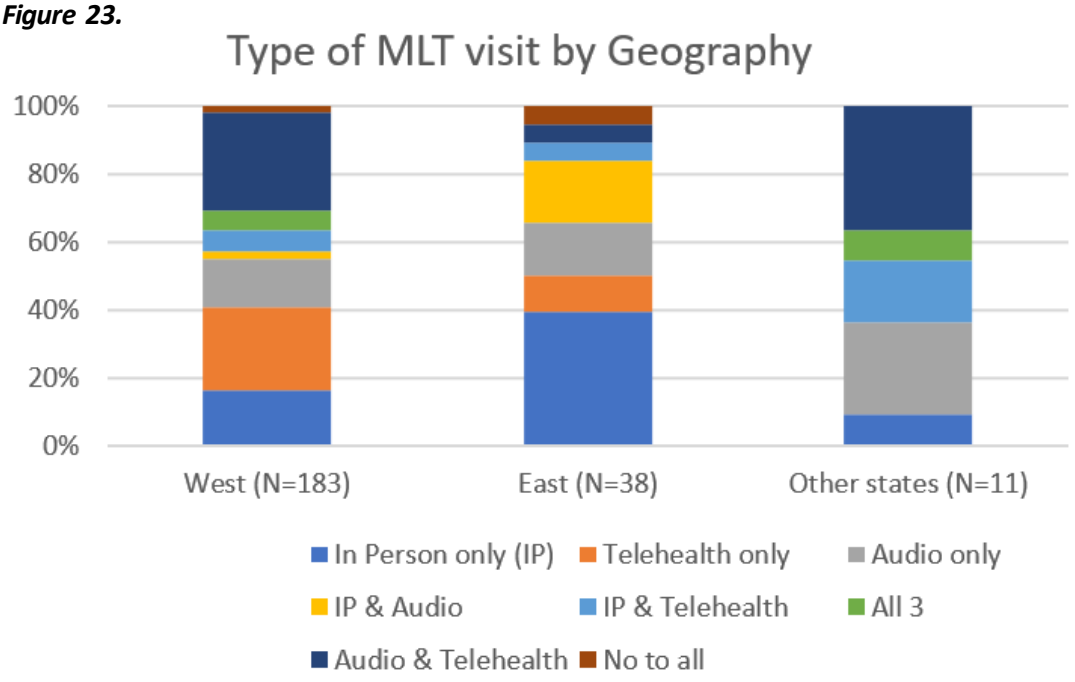
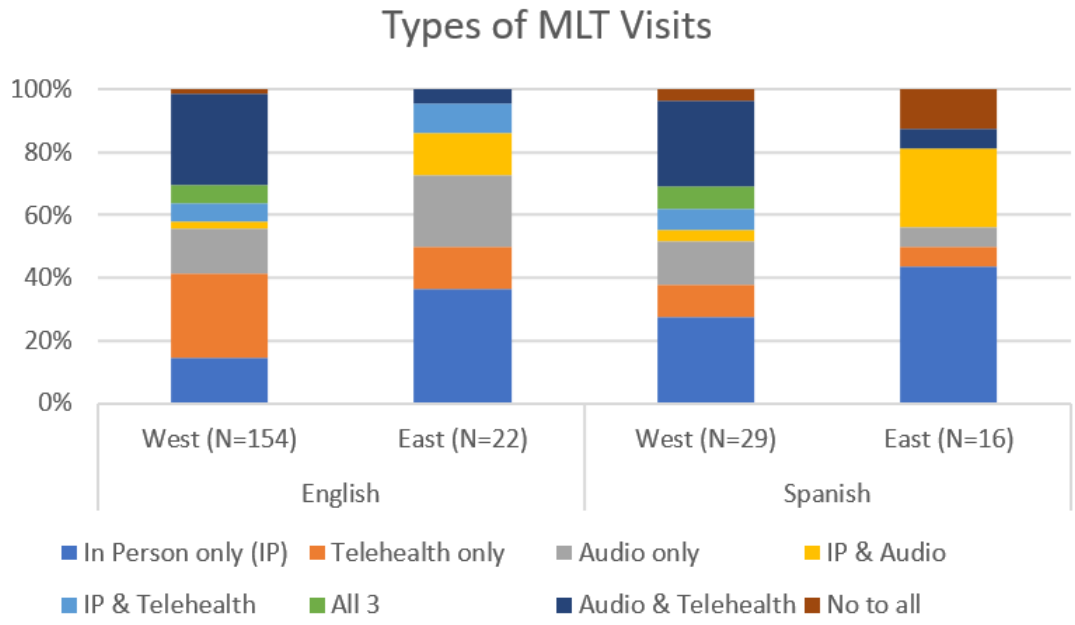


Figure 24.



Tables 13 through 16 report how those who had a mix of types of visits with MLTs had most of their visits.

Table 13. Of those who had visits by all 3 methods, how did you have most of your visits with the therapist(s)?

	English N=9	Spanish N=2
In-person	11%	100%
2-way video	33%	0%
Audio only / Telephone	44%	0%
Equal numbers of each type of visit	11%	0%

Table 14. Of those who only had in-person & telehealth (no audio-only visits), how did you have most of your visits with the therapist(s)?

	English N=11	Spanish N=2
In-person	55%	50%
2-way video	36%	50%
Audio only / Telephone	0%	0%
Equal numbers of each type of visit	9%	0%

Table 15. Of those who had in-person & audio-only visits (no telehealth) How did you have most of your visits with the therapist(s)?

	English N=6	Spanish N=5
In-person	50%	100%
2-way video	0%	0%
Audio only / Telephone	33%	0%
Equal numbers of each type of visit	17%	0%

Table 16. Of those who had no in-person but audio & telehealth visits, how did you have most of your visits with the therapist(s)?

	English N=46	Spanish N=10
In-person	0%	0%
2-way video	72%	70%
Audio only / Telephone	17%	30%
Equal numbers of each type of visit	11%	0%

The majority of survey respondents in both languages said the question about whether the MLT visits occurred during their work hours was not applicable since they weren't working (Table 17). Approximately 10% of respondents said their visits were outside of their work hours.

Table 17. Visits with the therapist(s) occurred ...

	English N=177	Spanish N=46
During my usual work hours	14%	11%
Outside of work hours	8%	11%
Sometimes during work hours	5%	13%
Not applicable since I was not working	73%	65%

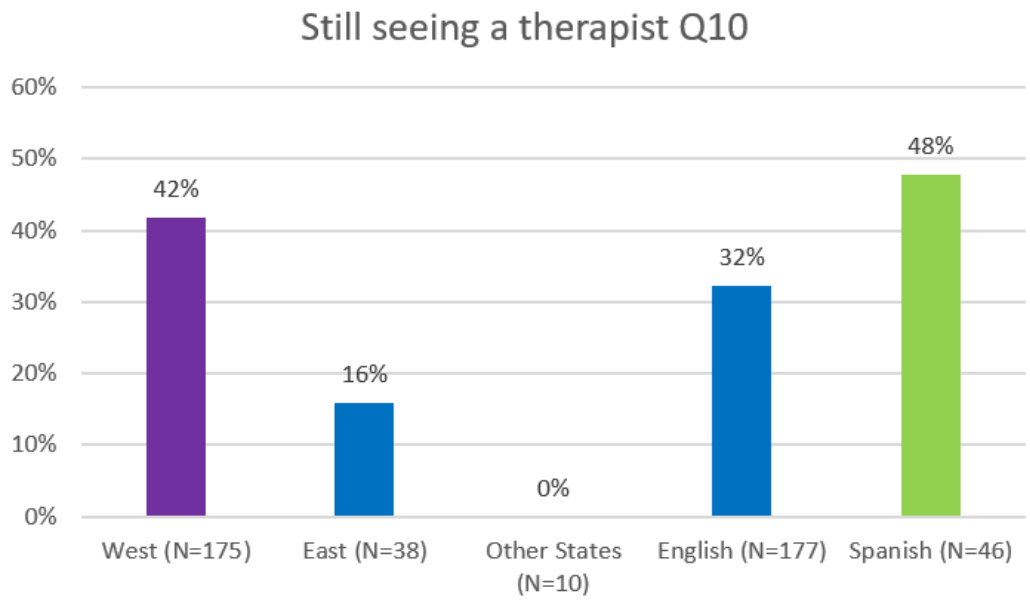
When looked at by state geography, the percentage of workers still seeing a therapist at the time of the survey was more than double on the western side of the state, compared to the eastern side of the state (Figure 25).

Visits Ended?

A little less than half (48%) of the English survey respondents said they were still seeing the therapist. Fewer (32%) of the Spanish survey respondents said they were still seeing the therapist.

Q10. Are you still seeing a therapist?

Figure 25.



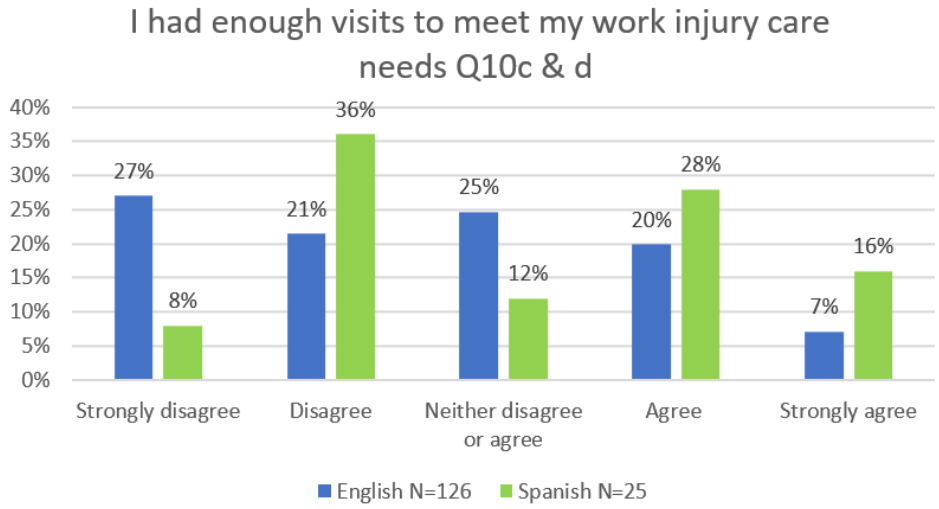
Almost all of those who said they were still seeing the MLT (89% and 95%) said it was for the work injury regardless of which survey (English vs. Spanish) was completed (Table 18). Because a large percentage of workers reported they were still seeing a therapist for their work injury we investigated this group further. We found that a few of the workers no longer had MLT bills submitted to L&I so the workers may have been self-paying for continuing visits or other insurance was being billed. Most workers who were still seeing the MLT had bills for MLT visits. Some had a mental health condition accepted for which they were receiving care and others appeared to have had an interruption in care with the MLT which extended their episode of care longer than would be expected.

Table 18. For the work injury or for unrelated personal reasons? [asked of those who said they were still seeing a therapist]

	English N=57	Spanish N=22
Work injury	89%	95%
Unrelated personal reason	11%	5%

English survey respondents disagreed (48%) more than agreed (27%) that there had been enough MLT visits for their work injury care needs (Figure 26). Spanish survey respondents agreed (44%) and disagreed (44%) equally.

Figure 26. Of those who were no longer seeing an MLT



There was interest in whether those who didn't feel they'd had enough visits had reached 8 or 16 visits and thus might have been denied further visits by L&I. Investigation of the number of visits is reported below. Since billing records are not perfect, the records of workers with 7-9 or 15-17 visits were reviewed, not just the records of those with 8 or 16 visits.

Of the workers who Disagreed (both Disagree options):

Workers completing the Spanish survey (N=11)

- 7 workers (64%) had 8 or 16 visits or were within 1 visit of that.
- 1 worker's claim closed after 3 visits

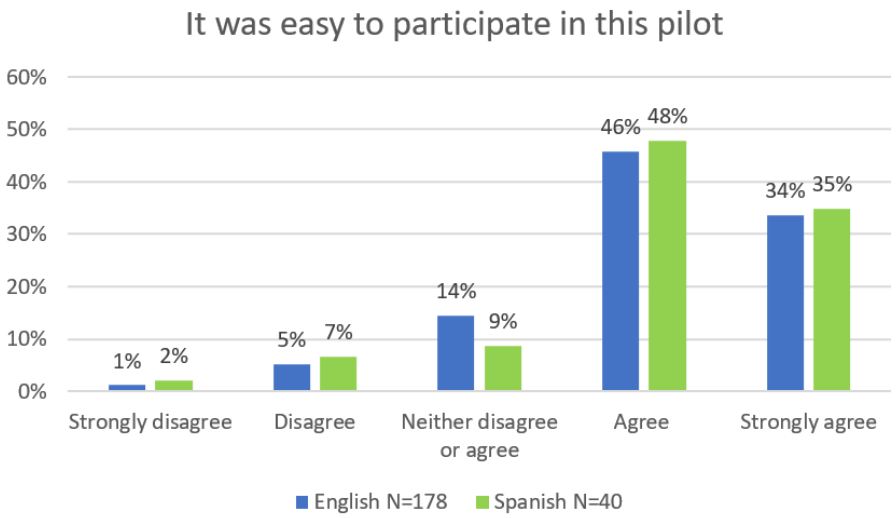
Workers completing the English survey (N=57)

- 37 (65%) workers had 8 or 16 visits or were within 1 visit of that.

Satisfaction

A majority of survey respondents, both of the English (80%) and Spanish (83%) surveys, reported that it was easy to participate in the pilot (Figure 27). *(wq11)* The small number of those who disagreed were asked what would have made it easier (*Q11b, wq11b*). Their open-ended responses are summarized below.

Figure 27.

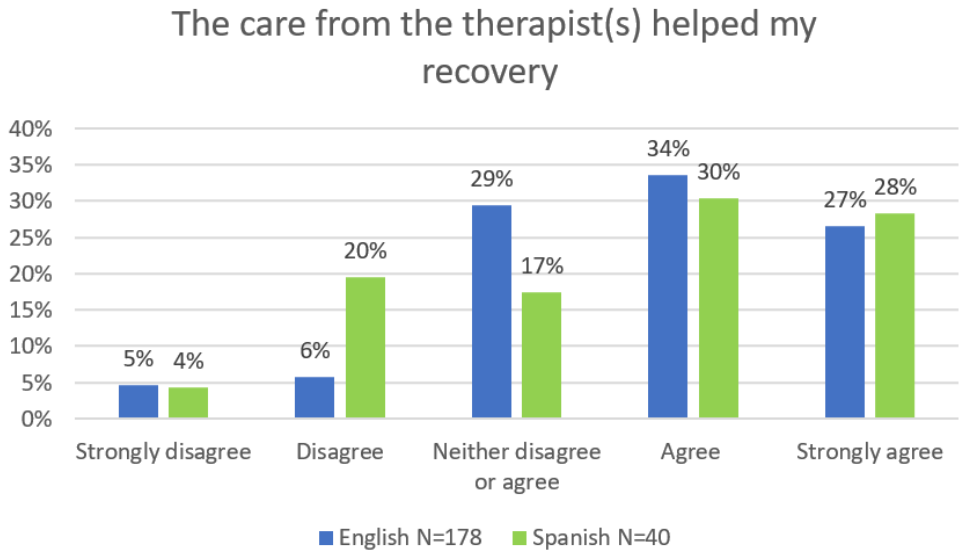


Spanish surveys: Of the four workers who said it was difficult to participate in the pilot and were asked what would have made participation easier, two didn't answer the question and two would have preferred an in-person appointment.

English surveys: The eight who responded to this question mostly mentioned difficulties getting approval for care from therapists: two mentioned difficulty getting the care started and two mentioned running out of visits when they still needed care. One worker said "The L & I manager threatened to make me pay for therapy if I didn't consent to her looking at my previous records." In addition, one detailed how the MLT was unhelpful and another worker said the attending provider was unhelpful.

When asked whether they agreed or disagreed that the care from the therapist helped their recovery, about the same percentage of English survey respondents agreed (61%) as Spanish survey respondents (58%) (Figure 28) and more Spanish survey respondents disagreed (24%) than English survey respondents (11%).

Figure 28.



Those who agreed were asked **Q12b. What was helpful?**

Of the 23 workers responding on the Spanish survey who agreed that the MLT helped their recovery:

- 22% mentioned treatment for stress, the emotional support, and emotional recovery
- 17% mentioned the helpfulness of the exercises "Things like breathing work or reading materials that they send me."
- 17% mentioned dealing with negative thoughts specific to work and/or the accident and accepting current circumstances.
- 13% mentioned that the therapist listened
- 13% mentioned that the therapist understood them
- 13% mentioned the advice given by the therapist
- 13% mentioned the professionalism of the therapist
- Other comments included: "Yes, I am not taking things so personally anymore. I'm also learning to say no and I'm working on it."

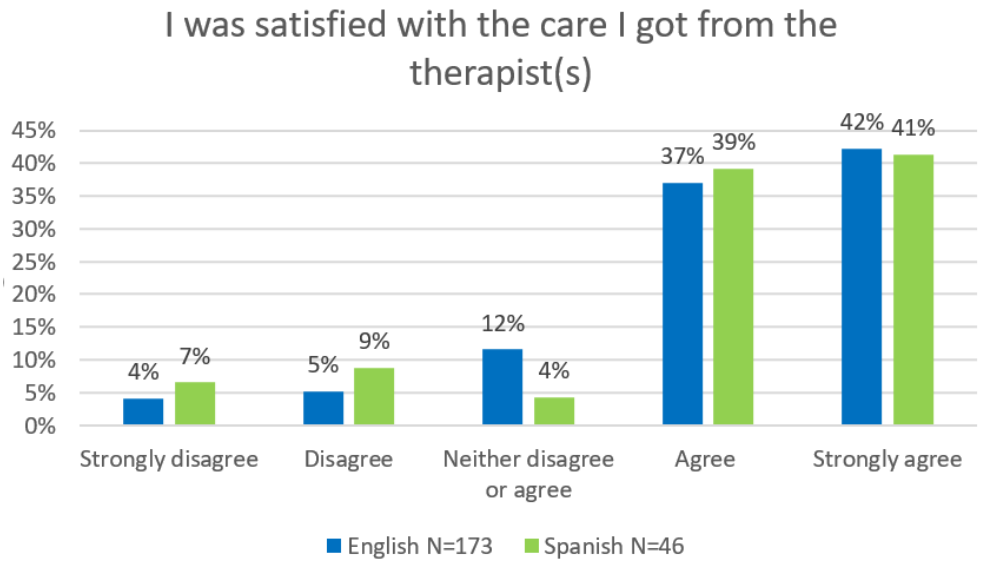
Of the 92 workers responding on the English survey who agreed that the MLT helped their recovery:

- 51% said it helped to have someone to talk to/listen/provide empathy
- 41% mentioned help with emotional recovery through coping skills/exercises/new insights
- 9% said it helped to have someone understand them or their situation
- 7% said the treatment led to acceptance of current circumstances after the injury
- 3% mentioned advice and/or resources
- 3% said therapy provided potentially life-saving support
- 14% had other mostly positive miscellaneous comments. Examples are shown below.
    - "She did her best with the limited time she had. It's too bad there was so few visits. I ended up needing to find another therapist on my own who I saw weekly for all the depression anxiety PTSD and suicidal ideation on my own."

- "In the extremely confusing system of L&I, my therapist genuinely felt like the only line of actual support I had. My vocational counselor was practically non-existent throughout the entirety of my claim (she only got involved in any sense when my lawyers eventually contacted her for information about the claim, I didn't even know who she was before then), my AP seemed to often have conflicting information, and the various claim managers I've had throughout my claim were often actively antagonistic. I learned most of how my claim worked and what was happening with it because of the help of my therapist, while also being provided with mental health assistance. Ultimately, her help was absolutely invaluable to me, and I'm extremely lucky to have been able to visit with her. I would have continued seeing her, but when she contacted my claims manager to request more visits (which is apparently supposed to be a fairly normal process if the therapist believes it's needed), my claims manager apparently said, verbatim: "We shred those" (referring to those kinds of requests)."
- "She was kind and knowledgeable. I was also going through a divorce and grieving my mom's death from Covid."
- "[the MLT] is a truly gifted therapist who cares and is in tune with the needs of an injured worker. We clicked right off the bat which is refreshing, to say the least in regards to my last 2 go-arounds with an injury. She was there for me and helped plot out a path forward."

As can be seen in Figure 29, a majority of the respondents in both languages expressed satisfaction with the care they received from the therapist.

Figure 29.



The small percentage that were dissatisfied were asked why. The Spanish survey respondents mentioned lack of improvement or needing more care as the reasons for their dissatisfaction. Neither of those was mentioned by those responding to the English survey. The English survey respondents mentioned negative interactions with the therapist which included the therapists repeatedly dozing off, the therapist "gave up on me," that the therapist didn't seem to care, or that the therapist had poor boundaries. A more detailed summary follows. All the comments can be read in Appendix 7B.

Why were you dissatisfied?

Spanish survey – 7 workers answered:

- 57% said they didn't improve
- 43% said they didn't have enough time to improve or their sessions got cut off
-

English survey – 16 workers answered:

- 50% mentioned negative interactions with the therapist
- 31% said the therapist was inconsistent or unreliable
- 13% said the approach or tools were not helpful
- 13% mentioned unrelated issues
- One said "I was taken for $50. Provided a deposit and was never reimbursed"

Another measure of satisfaction with the care of the therapist is likelihood of recommending the therapist to a friend. All respondents were asked this question. A majority agreed (Figure 30).

Figure 30.

All of the workers' responses to the question "**What would you like L&I to know about your care from the therapist(s) in this pilot?**" (wq15) can be seen in Appendices 7a and 7b, but a summary follows.

Spanish surveys – 46 answered:

Of those who had something to say, most respondents said something positive about their therapist.

- 48% Received good treatment from therapist
- 18% Therapists provide needed emotional/mental health support after accident

- 7% Importance of & need for reliable interpreters or Spanish-speaking therapists
- 7% Had complaints about L&I
- 5% Would prefer in-person visits
- 5% There were not enough visits

Two comments didn't fit in a category

- "They don't treat you well. They didn't talk to me about my injury, or explain to me why L&I kept cancelling my appointments with the therapists and doctors."
- "In reality, they are very simple advice and questions, almost like what a relative would give you."

English surveys – 170 answered:

- 60% Talked about the positive experience with the therapist
- 18% Wished treatment visits had continued longer
- 7% Had a negative experience with the therapist or the treatment meet their needs
- 6% Random other comments sometimes complaints about L&I
- 4% Wish they could have seen the MLT earlier in the claim
- 4% Other positive comments about the MLT
- 4% Other negative comments about the MLT
- 2% Would prefer in-person appointments or didn't like telehealth appointments
- 2% It was difficult to get in-person appointments
- 2% It was difficult to find a therapist participating in the pilot
- 1% Communication was poor about referral and participation

Spanish Surveys

The Spanish survey included a few additional questions about the use of interpreters. Roughly half often or always used an interpreter and another half never used an interpreter (Table 19). In retrospect, a question asking why (e.g., I speak adequate English, The MLT spoke Spanish) would have been useful for those that answered "never" or "rarely."

Table 19. I used an interpreter with this therapist

Responses	N=45
Never	47%
Rarely	0%
Sometimes	4%
Often	4%
Always	44%

Table 20. Were there times you wanted an interpreter but one wasn't available?

Responses	N=45
Never	80%
Rarely	2%
Sometimes	7%
Often	7%
Always	4%

Workers were asked about concerns they might have with having an interpreter with their therapist visits. The large majority,35 of 45 (78%), said they had no concerns. The small number (10) with concerns said the following:

- 3 workers talked about the importance of having the interpreter for accurate communication including one who hadn't had an interpreter but said "there were times that an interpreter would've been helpful because there were some things she [the therapist] doesn't know in Spanish."
- 3 workers mentioned that the interpreters were not always accurately interpreting. "I also understand a lot more than I can speak. I know when interpreters are not expressing what I am saying and I don't have a problem telling them that they are wrong. I think the interpreters need to be picked out better because they sometimes don't do an accurate job. I didn't want to have an interpreter in the room misinterpreting what I'm saying to the therapist."
- 2 individuals mentioned their discomfort with having a 3rd person hear their conversation
- 1 worker didn't trust the interpreter(s): "Sometimes, I don't know if I should trust them. I don't know if they are part of L&I and they might tell them what I say."
- 1 worker complained about the unreliability and lack of professionalism of the interpreter(s): "Most of the time the interpreters arrived late or at the end of my appointment. The majority of times the interpreters wouldn't translate, and they spent their time on the phone."
- Another worker said, "I wish they could give us a list of therapists that speak the language of our preference instead of having to use interpreters."

All the comments can be read in Appendix 7b.

Conclusions

Online surveys were conducted in 2022 of (1) four groups of MLTs, (2) L&I claim managers, and (3) workers who saw MLTs. The four MLT groups were those who were participating in the pilot at the time of the surveys, those who had withdrawn from the pilot, MLTs who completed the required training but didn't join the pilot, and MLTs who belong to professional associations in Washington state but weren't in any of the other groups.

The response rate for MLT participants in the pilot was 63% but the other MLT groups' response rates and those of the workers were less than 50%. The answers and comments may not be representative of the whole population of especially the workers and other MLT survey respondents. Nonetheless, the survey results are useful for L&I's planning purposes and the comments have a wealth of ideas. In addition, the worker survey results must be interpreted keeping in mind that the workers identified were seeing the MLTs in 2020 and 2021, during the SARS Covid-19 pandemic.

Assessment of MLT Pilot Objectives

Access to care

Questions asked of the claim managers, MLTs and workers assessed access to care which all agree had improved. We were only able to survey workers who were treated by an MLT, and not those who were unsuccessful in obtaining care. Therefore, worker survey responses may not represent all experiences with access to care.

- A majority of claim manager survey respondents (69%) said 50% or less of providers were aware of the pilot. Still respondents said that access to behavioral health interventions had improved (75%).
- MLTs' most reported benefit of the MLT pilot was increased access to support and treatment for workers.
- More workers responding to the Spanish survey on the western side of the state (58%) found it easy to find a therapist than those on the eastern side of the state (44%). The worker respondents to the English survey said it was easy equally on the western (42%) and eastern side of the state (41%). One must keep in mind that these are workers who succeeded in obtaining MLT services.
- A majority (69%) of those responding to the English survey said the AP selected the MLT for the worker whereas this was the case for only 41% of those responding to the Spanish survey. A much higher percentage of Spanish survey respondents (38%) used the Find-a-Doc website to find their own therapist than English survey respondents (6%).
- In the worker surveys half (50% of English survey respondents) or more (71% of Spanish survey respondents) of the workers said they traveled about the same distance to see the MLT in person as they travel to see other health care providers. Only 37% (24% of those in Western Washington, 54% in Eastern Washington) of those responding to the English survey ever saw the MLT in person. This report provides additional detail about the types of MLT visits.
- A larger percentage of those completing the Spanish survey (79%) than English survey (58%) said that getting to appointments was convenient. More of those on the western side of the state

(84%) versus the eastern side of the state (72%) found it convenient. Those completing the English survey found the convenience approximately the same whether on the eastern (62%) or western (56%) side of the state. One must keep in mind that these are workers who succeeded in obtaining MLT services.

- Workers accessed MLT care via in-person sessions, telehealth (2-way video or audio only/telephone) sessions, and a combination of in-person and telehealth. This flexible delivery method (allowing in-person and telehealth) may improve access to behavioral health care for injured workers.

Opportunities for improvement in the timing and delivery of MLT services

Most of the MLT pilot participants had no suggestions for improving the timing of treatments for workers. Of those who did respond to the question, most said referrals need to occur earlier in the claim. Only a couple had more specific suggestions.

- "Continuously educating the community- Attending Providers (APs), VRC and other stakeholders- regarding the program so they will refer workers when needed, without delay."
- "Having AP's refer anyone who's been injured more than 3 months to a counselor"

There were not a lot of suggestions related to improving delivery of services. "Procedural improvements" were suggested but without any further specifics except the following two.

- "A cheat sheet or reference site with a flow chart with each step and requirement and links to each document to aid in providing all required info."
- "Allow access to CAC [Claim and Account Center]." This was mentioned quite a few times.

Educational and training needs

As a group, MLTs describe having training and experience in treating symptoms such as anxiety, depressive symptoms, and trauma that injured workers may face. The results suggest that some may be less prepared for managing RTW, pain, and other aspects specific to having a work injury. Although those who participated in the pilot felt somewhat or completely prepared to treat clients with work injuries, only 24% of the association respondents reported being completely prepared. This may simply reflect that they lack awareness of the program's billing and administrative procedures; however, it may also indicate that many do not feel fully prepared to work with the psychosocial or medical aspects of a client with a work injury. Similar findings were found regarding assisting clients to RTW after a work injury; only 24% felt completed prepared to assist with this (amongst the association respondents). Additional training in pain management was the most frequently requested suggestion by those who participated in the program, underscoring the desire for more training on this topic.

The results suggest that MLTs may benefit from additional training in working with injured workers on RTW issues, the PDIR, and chronic pain. For example, as shown in Chapter 1, Table 17, only a third of the pilot participants reported being familiar with the PDIR, despite it being covered in the training and many of the PDIR barriers to injury being reported as issues addressed by MLTs who treated L&I workers in the pilot (Table 19). Additional training in these topics may be particularly important for new MLTs recruited from the professional associations. For example, regarding preparedness for working with injured workers with pain, only 27% of association survey respondents felt completely prepared (Table 14), and only a third (36%) have had training in pain management techniques, and fewer are familiar with the biopsychosocial model of pain. Many said they wish they had more training in pain management (11/39 pilots); others also reported wanting to know more about other L&I processes. It

may be that the MLTs who initially enrolled and participated in the pilot had experience working with clients with work injuries, chronic pain, or other health conditions, which may predispose them to being more comfortable with the L&I clients. Supporting this idea is the fact that 83% of the pilot participants reported having training in specific pain management techniques, whereas only 36% of the association respondents reported having this training.

Since only 21% said the required L&I MLT training was very helpful and no one said "extremely helpful" there is an opportunity to improve it. There is a desire for additional training on L&I billing procedures, and continued access to training materials after completion. Several MLTs suggested training about the needs of injured workers, perhaps using case studies of injured workers with experienced providers.

Other Survey Results

MLT Surveys

Most of the MLTs who participated in the pilot and treated injured workers were generally satisfied with the program. They identified several benefits to the workers, including increased access to support/treatment and improved mental health. They also described benefits to them as providers, including that the work was rewarding and a source of referrals.

Barriers to MLT Pilot participation

One striking finding that emerged from the association surveys was how few MLTs – only 5%- were aware of the MLT pilot program. Only 25% of those who participated in the pilot learned about it from L&I, suggesting a multi-prong outreach effort may be needed to enroll more participants.

The main barriers MLTs experience to increasing the number of workers in their practices are (1) their practices are full and (2) the paperwork burden that accompanies treating workers.

Reducing paperwork and other administrative barriers was a common recommendation for improvement. A number of administrative challenges paid were reported (see Chapter 1, Table 27); for example, as many as a third of the pilot participants reported administrative challenges with paperwork, charting /reapproval, getting paid, and referral issues. Some also reported not getting paid for their services which may negatively impact not only that MLT's willingness to see injured workers but also other MLTs who hear about such difficulties. In a climate where mental health services are in high demand overall, these types of barriers may negatively impact MLTs' willingness to take L&I cases, given such work may decrease their income or take them away from seeing other clients. For most MLTs in private practice, paperwork and administrative processes are simple, quick, and result in prompt or immediate payment (e.g., client pays MLT and gets reimbursed by their insurance).

Claim Manager Surveys

A majority of claim manager survey respondents (69%) said 50% or less of providers were aware of the pilot.

Most respondents did not report barriers to providers making MLT referrals, although at the same time they reported a low percentage of providers were aware they could refer to MLTs. The claim managers also were not aware of barriers to workers receiving MLT services after the referral.

A majority of respondents (75%) said that MLT-provided behavioral health services are the same or better than those provided by psychologists/ psychiatrists or psychiatric advanced registered nurse practitioners (ARNPs) (Chapter 2, Table 12).

Nearly all (88%) claim managers reported no change in the number of mental health diagnoses contended in their caseload.

Worker Surveys

The majority of surveyed workers reported being satisfied with the care they received from their therapist and would recommend their therapist to a friend. Most also said the care from the MLT helped their recovery (61% English and 58% Spanish). When asked what helped most, the majority said it helped to have someone to listen to them or to have someone with empathy to talk to. There were a very few workers who described less than ideal interactions with their MLT.

Barriers to care cannot be completely assessed without the input of the workers who were unable to obtain MLT services.

Almost half (47%) of the Spanish survey respondents never used an interpreter. Although most (80%) of survey respondents reported never having times when an interpreter wasn't available, 20% did have that experience. Most (78%) of the Spanish survey respondents had no concerns with using an interpreter for their MLT appointments. For those who did report concerns, the most common issue was the accuracy of the interpreter's interpretation, but discomfort with a 3rd person hearing the conversation, distrust of the interpreter, and unprofessional interpreter behavior were also mentioned.

Recommendations

Suggestions for expanding the program:

- As most of the MLTs who participated in the pilot were LICSWs or MHCs, L&I may want to focus outreach efforts on LICSWs and MHCs, rather than MFTs. As a group, MFTs may be less interested in providing 1:1 therapy to injured workers.
- Recommend reaching out to the LICSW (The Washington State Society for Clinical Social Work) and MHC organizations (e.g., the Washington Mental Health Counselors Association) and communities, as there may be MLTs within those organizations who have interest in and capacity for treating injured workers.
- Engage with stakeholders from the MLT community to learn from them how to enroll more participants and make it attractive for the organizations to promote the program and reduce real or perceived barriers to enrolling/participating in the program.
- Several MLTs commented on having full caseloads/practices. This is a real barrier that may interfere with adding MLTs. Consider outreach to graduate programs as an opportunity to capture MLTs early in their careers as they build their practices.
- Offering CEs (suggested by several MLTs) might be one way to engage MLTs in the program.

Suggestions for MLT training:

- Provide more training on the medical and psychosocial aspects of work injuries (perhaps a 2--4-hour training either online asynchronous or live webinar)?

- Provide more training on the biopsychosocial model of pain and pain management techniques, including how to engage injured workers in using proactive/active coping strategies and avoiding inadvertently reinforcing unhelpful messages about pain.
- Provide more training on the administrative aspects of the L&I referral and claims process.
- Have resources easily available for MLTs to review, including training transcript download, other resources, and the PDIR.
- Provide continuing education credits to MLTs who participate in trainings to entice more MLTs to participate in the training and MLT program. This could be administered via or co-sponsored with the professional associations, which may defray the administrative burden and costs associated with providing continuing education credits.

Suggestions for L&I administrative processes:

- Provide a template/example note that would meet L&Is processes for payment that could be shared with MLT providers to demystify documentation requirements.
- Have a champion at L&I they can contact if they have questions-someone who delivers "customer service" to the MLTs. This person could help with questions during the process of signing up for treating workers, further educate claim managers and attending providers about MLTs, fine tune the MLT education and orientation materials, work regularly with the professional organizations and graduate schools to raise the visibility of this career option and reduce barriers to participation.

Suggestions from Worker Surveys

- Ensure that bilingual therapists can be identified easily by attending providers and workers.
- Communicate in some way to workers that they can change to a different MLT if the one they begin with is not "a good fit."
- Continue to allow sessions to be delivered in-person, by telehealth (video and audio/telephone), or a combination of both, based on workers' preferences and needs; this flexibility may allow workers to have better access to and engagement in care.

[1]PA Harris, R Taylor, R Thielke, J Payne, N Gonzalez, JG. Conde, Research electronic data capture (REDCap) – **A metadata-driven methodology and workflow process for providing translational research informatics support**, *J Biomed Inform. 2009 Apr;42(2):377-81.*
[2]PA Harris, R Taylor, BL Minor, V Elliott, M Fernandez, L O'Neal, L McLeod, G Delacqua, F Delacqua, J Kirby, SN Duda, REDCap Consortium, **The REDCap consortium: Building an international community of software partners**, *J Biomed Inform. 2019 May 9 [doi: 10.1016/j.jbi.2019.103208]*

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