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OHIO PILOT PROGRAM STEPS UP WORKERS' COMPENSATION EFFECTIVENESS

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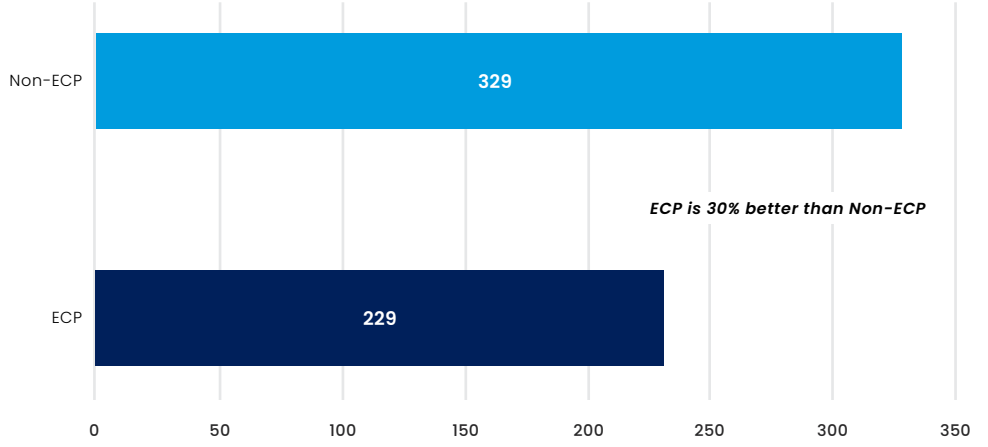
This case study addresses a fundamental for HR leaders — how to get injured employees (and by extension sick ones) back to work and keep them there.

In July 2015, the State of Ohio Bureau of Workers' Compensation (BWC) embarked on a pilot program for workers with knee-only injuries called the Enhanced Care Program (ECP) (Ohio BWC n.d. a). This paper examines the research into the program's effectiveness. To accumulate enough data to evaluate if ECP worked, the bureau had to wait awhile. The wait is over, and the results are now in — and they are significant.

If you had to condense success in workers' compensation down to a single metric, it would be how fast you return an injured employee to work. ECP claims outperformed the claims not in ECP (non-ECP) by 30% (Ohio BWC n.d. a).

FIGURE 1 Average Number of Days to Return to Work



You would think that to get these better results, you would have to pay more. The bureau, however, paid less — much less. The pilot saved an estimated $2.1 million.

HR executives can apply ECP's principles and metrics not only to workers' compensation programs, but to their employee health plans too.

And then there is the soft cost of organizational productivity. When employees are out because they are sick or injured, stress goes up while efficiency and effectiveness go down. Other employees or temporary workers attempt to fill the breach, but being unfamiliar with the tasks, they may perform them poorly, take too long or not get them done at all. Adding insult to injury, this decrease in productivity comes at the additional cost of overtime and temp agency fees. You may even find that the more stressful environment causes otherwise healthy employees to become sick too.

WORKERS' COMP 101

For those unfamiliar with workers' compensation, here's a quick primer: Workers' compensation varies state by state. The concept is that when an employee is injured on the job, workers' compensation pays their medical costs and replaces lost wages. Workers' compensation insurance purchased by the employer is the exclusive remedy. (Under certain circumstances, an employer can self-insure. In Texas, an employer can opt out of the workers' compensation system entirely.) It's a no-fault system. In exchange for these benefits, the injured employee can't sue their employer.

The statutory benefits fall into two buckets: first, payments to the doctors and other medical providers who treat the employee; second, payments to the employee, referred to as "indemnity." The most common indemnity benefit replaces income lost because the employee couldn't work, paid at a percentage of their average wage.

HOW OHIO IS DIFFERENT

Ohio is one of the few monopolistic states for workers' compensation. If you're an employer in Ohio, you purchase your workers' compensation insurance directly from the state. (The other monopolistic states are North Dakota, Washington, and Wyoming, as well as Puerto Rico and the U.S. Virgin Islands.)

Established in 1912, the Ohio Bureau of Workers' Compensation is the exclusive provider of workers' compensation insurance in Ohio, serving 257,000 public and private employers. With nearly 1,600 employees and assets of approximately $21 billion, the bureau is one of the largest state-run insurance systems in the United States (Ohio BWC n.d. a). The bureau focuses on providing the right care, at the right time and in the right setting.

The bureau carries this out through the Health Partnership Program (HPP) with 10 managed care organizations (MCOs). HPP is a public-private collaboration in which the MCOs manage the workers' compensation claims for the bureau, including authorizing treatments and processing provider payments. Each employer selects an MCO to manage its employees' injuries. The bureau issues annual scorecards on the MCOs to use when making that selection.

Key to the effectiveness of the partnership program is a strong network of certified providers, including doctors and facilities for the injured employees to see. A provider who wants to treat work-related injuries completes an enrollment and certification application. Once approved, the provider becomes part of the bureau's provider network.

In 34 states, an employer can direct care to varying degrees and tell the injured employee which doctor they must go to (Roloff et al. 2021). Not in Ohio. An injured employee has freedom of choice and can go to any provider in the network.

Although these things make Ohio unique, what Ohio did with the Enhanced Care Program applies to every state's workers' compensation regimen.

ENHANCED CARE PROGRAM

Workers' compensation can be a bureaucracy of red tape, delays and waste. While Ohio was better than most, the bureau knew that it could do better. In September 2014, the bureau held a five-day healthcare summit for its stakeholders: employers that pay the premiums, labor who represent employees, healthcare providers and the MCOs. From that summit, the Enhanced Care Program was born (Ohio BWC n.d. a).

The bureau and its stakeholders designed ECP so that injured employees with knee-only injuries would receive faster treatment resulting in an earlier return to work at lower costs. ECP also gave physicians more flexibility to render care than traditional Ohio workers' compensation rules, simplified the treatment authorization process, and encouraged comprehensive treatment planning. A hoped-for side benefit was that this freer environment and more holistic approach would remove some of the barriers to care and improve the satisfaction of the injured employee, employer and physician.

In July 2015, the bureau began the ECP pilot in 16 northeast Ohio counties for employees with work-related knee-only injuries (Ohio BWC n.d. b). Physicians enrolled in the program, known as ECP physicians of record (PORs), agreed to enhanced responsibilities, including:

- Providing timely access to care (ideally within 48 hours)
- Agreeing to be measured
- Documenting a comprehensive treatment plan
- Creating a timeline for return to work
- Identifying barriers to injury recovery and return to work
- Engaging the employer in coordination with the managed care organization
- Educating the injured employee about their injury.

In return for participating, the bureau paid physicians 15% more for their office visit services.

Under the program, the physician establishes a comprehensive care plan from the date of injury to the employee's return to work and is empowered to treat both allowed knee conditions and other not-yet-allowed knee conditions that the physician thinks are causally related to the work-related injury. A condition is allowed when the bureau determines that it occurred during the course, and arising out of, employment or is otherwise approved. The ECP also introduced a new treatment request form to streamline the administrative process and facilitate care coordination among providers, including between PORs and the patients' primary care physicians (BWC n.d. c). The bureau's standard treatment request form reflected an episodic approach to treating a work-related injury. The new form focuses on the whole needs of the injured employee, looking ahead to what would be needed.

After the initial claim determination, the ECP separated the medical and legal components, allowing treatment without affecting any party's due-process or appeal rights. (If an appeal is filed, however, traditional bureau processes are followed instead of ECP.) For example, the physician could begin treatment upon the bureau's claim allowance and continue it for 60 days without waiting for the MCO to approve the treatment plan, so long as that treatment fell within the "green" ODG guidelines (formerly the Official Disability Guidelines). (Under certain circumstances, PORs may treat outside the green guidelines, although this requires documentation justifying the treatment.) ODG is part of the Hearst Health Network and provides evidence-based care guidelines built from its nationwide database of non-occupational disability and workers' compensation injuries. ODG's "Treatment Analyzer on Outcomes" maps current procedure terminology (CPT) codes to international classification of diseases (ICD) diagnosis codes to produce utilization payment flags. A green flag indicates that the treatment conforms with ODG's evidence-based guidelines that reference studies published in peer-reviewed medical journals (ODG n.d.).

After a year, the bureau contracted with The Ohio State University College of Public Health to evaluate the program's foundation, survey ECP physicians and provide recommendations. One of those recommendations was that the bureau have a consultant analyze ECP's results after enough time had passed to accumulate sufficient longitudinal data on each injury. In 2022, the bureau engaged IntegerHealth Technologies, a Fort Worth, Texas-based healthcare analytics company, to analyze ECP's results on knee injuries occurring from July 2015 through June 2018, and compare them to knee injuries during that period in the pilot's 16-county area that were not treated as part of the pilot. IntegerHealth analyzed data on these injuries from July 2015 through March 2022. Accordingly, there was almost four years of possible data on the most recent injuries (i.e., those occurring in June 2018) and almost seven years on the oldest (i.e., those occurring in July 2015).

IntegerHealth's report, which was presented to the bureau's board of directors and is a public record, is the source for the analytics cited in this case study (IntegerHealth 2022). (To access IntegerHealth's report, go to the bureau board's website at https://ohiobwc.boardeffect.com/workrooms/2900/events/791584/books/904744 and enter Username: guest and Password: guest1234, expand the "New Business / Action Items" section of the Sept. 29, 2022, meeting of the Medical Services and Safety Committee, and click on "IntegerHealth Report on Ohio BWC ECP.")

FOLLOW THE MONEY

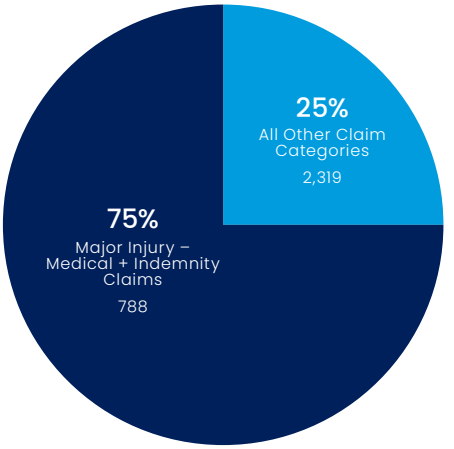
There were 3,107 knee-only injuries from July 2015 through June 2018 in the 16-county pilot area — 1,198 were treated in the pilot program, and 1,909 were not part of the pilot and served as the control group (i.e., receiving treatment under traditional Ohio workers' compensation processes). IntegerHealth divided these injuries into two groups: "major injuries" potentially requiring surgery (e.g., torn meniscus, torn ACL, knee replacement, etc.), and "minor injuries" (e.g., strains, sprains, contusions, etc.). It then further divided these groups into two categories: those which incurred both medical costs and some form of indemnity payment, and those which incurred medical costs only.

TABLE 1 Breakdown of ECP and Non-ECP Knee Injuries

	ECP	Non-ECP
Major Injuries	Major Injuries — Medical + Indemnity 367 Claims	Major Injuries — Medical + Indemnity 421 Claims
	Major Injuries — Medical Only 189 claims	Major Injuries — Medical Only 307 Claims
Minor Injuries	Minor Injuries — Medical + Indemnity 133 claims	Minor Injuries — Medical + Indemnity 248 claims
	Minor Injuries — Medical Only 509 claims	Minor Injuries — Medical Only 933 claims

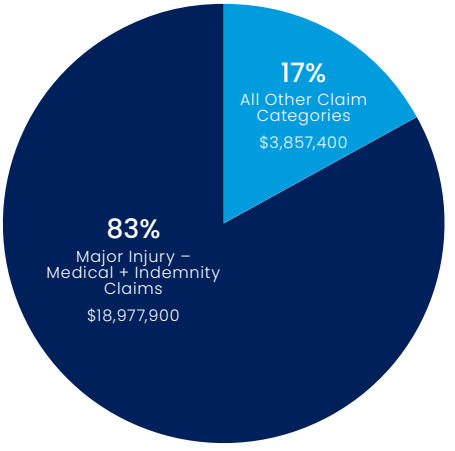
From this breakdown, it became clear where the action was. Of the 3,107 injuries, only 25% were in the "Major Injury–Medical + Indemnity" category.

FIGURE 2 Number of Claims



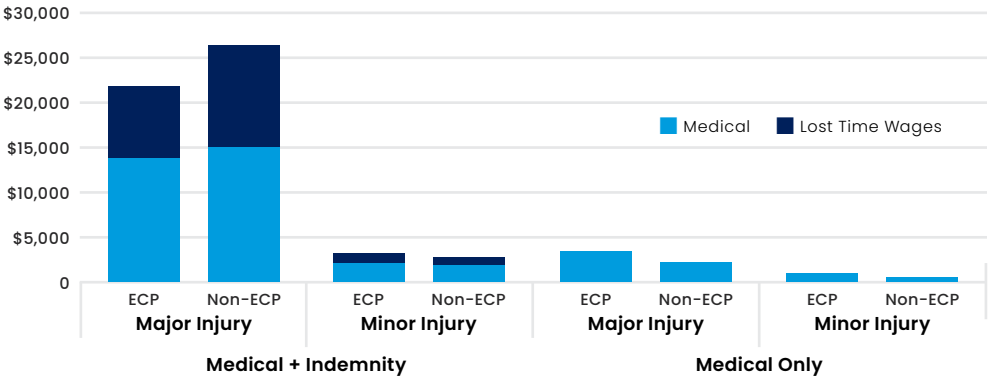
But they accounted for 83% of the total medical costs and lost-time wages. (Recall that "indemnity" encompasses a range of payments to an injured employee, including lump sums for permanent or partial disability and lost-time wages. When categorizing injuries, the distinction is made between indemnity or no indemnity. When monetizing the injuries, however, only the lost-time wages were combined with the medical costs because the other forms of indemnity were considered beyond the provider's control. In the IntegerHealth report, the lost-time wages are referred to as "temporary total," which is the nomenclature that the bureau uses for them.)

FIGURE 3 Medical and Lost-Time Costs



The average cost per claim was as follows, with ECP 18.8% better than non-ECP in the most significant category by far: major injuries with medical and indemnity costs.

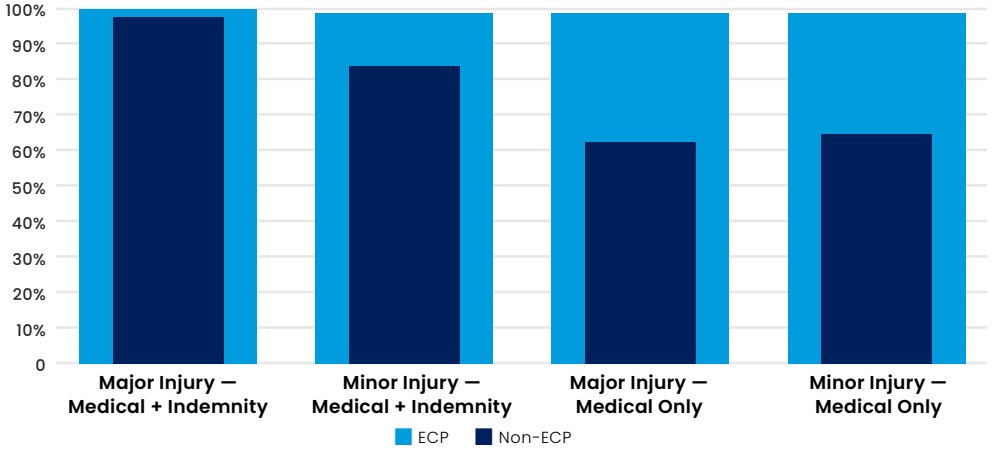
FIGURE 4 Average Costs



In the other categories, however, ECP was slightly more than non-ECP. There are several reasons for this. First, ECP has a 15% higher fee schedule for office visits than non-ECP, which is one of the incentives used to recruit physicians into the program.

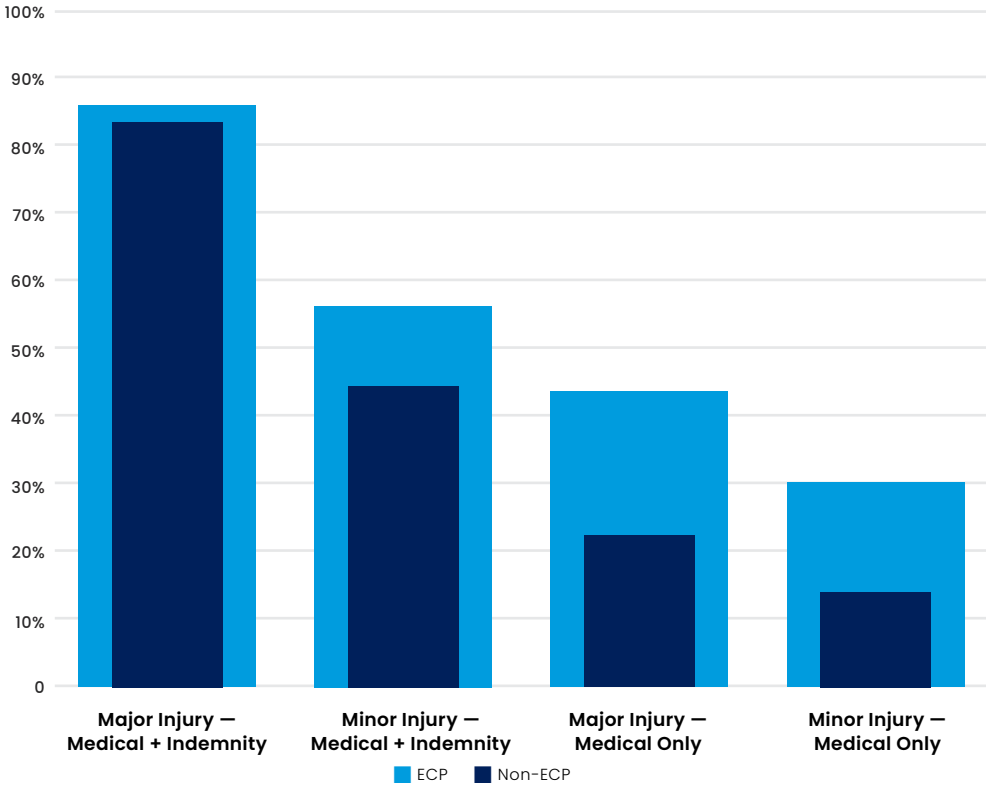
Second, ECP ensures that injured employees see a provider (e.g., physician/doctor, physician assistant, nurse practitioner, etc.) — always a good thing and one of the points of emphasis for the program. Figure 5 shows the percentage of claims in each category with at least one outpatient provider visit included in their medical costs. The blue columns show these percentages for ECP, while the dark blue columns within them the corresponding percentages for non-ECP, demonstrating how ECP exceeded non-ECP in each category. All claims had some medical, so those without a provider visit may have gone to a hospital emergency department and then never saw a provider after that.

FIGURE 5 Claims with a Provider Office Visit



Third, ECP uses physical therapy more often than non-ECP — also a good thing, because physical therapy is less invasive than injections and surgical procedures. Figure 6 shows the percentage of claims in each category with at least one physical therapy session.

FIGURE 6 Claims with a Physical Therapy Session

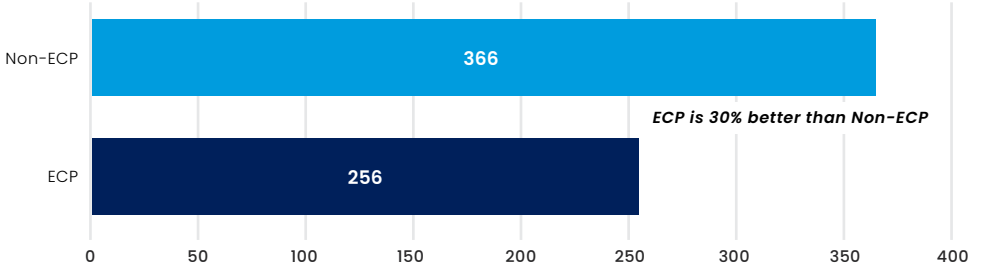


RETURN TO WORK

As emphasized at the beginning of this case study, if you could pick only one metric to judge how well a workers' compensation program is doing, it would be "Return to Work." It encapsulates everything. First, the reason for a workers' compensation program is to get injured employees back to work — safely and in a sustainable manner that doesn't find them back home with a relapse or re-injury in a few weeks. Second, return to work is an indication of the effectiveness of the medical care — the quicker a provider gets an employee back to work, the more effective the provider was. Third, making lost-time wage payments to injured employees while they are unable to work is a significant cost.

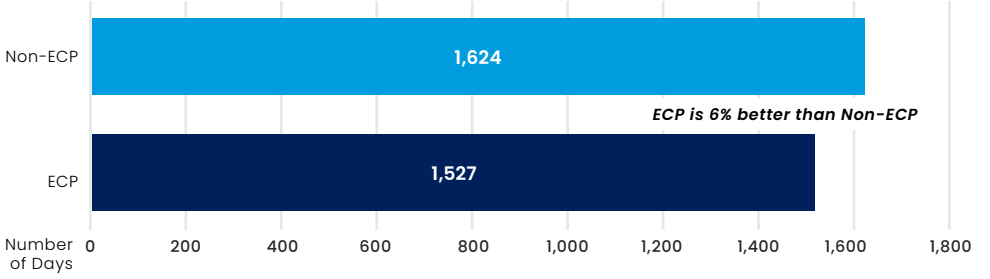
ECP's return-to-work average for all claims was 30% better than non-ECP's. This 30% advantage held when measuring return to work for the most severe injuries (major injuries with medical and indemnity costs), although the number of days in this category increased above the overall average by more than 11%.

FIGURE 7 Average Number of Days to Return to Work — Major Injury, Medical + Indemnity



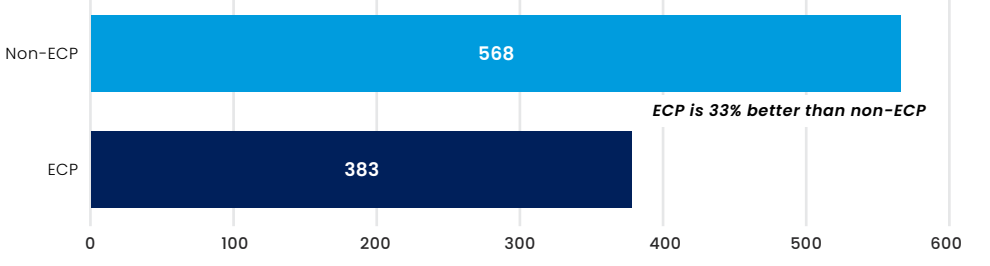
Two things that dramatically affect return to work are behavioral health diagnoses and opioid use. For major injuries with both medical and indemnity, the average number of days to return to work for employees with at least one behavioral health diagnosis ballooned from 256 to 1,527 days for ECP and from 366 to 1,624 days for non-ECP.

FIGURE 8 Behavioral Health — Major Injuries with Medical + Indemnity Average Number of Days to Return to Work



The use of opioids in the treatment of an injured employee also signals a longer return to work. Whether causal or correlative depends on the case. Return to work for employees with a major injury with both medical and indemnity who received opioids increased from 256 to 383 days for ECP and from 366 to 568 days for non-ECP.

FIGURE 9 Opioids – Major Injuries with Medical + Indemnity Average Number of Days to Return to Work



OTHER KEY METRICS

There are other key metrics in workers' compensation (IntegerHealth 2022). These claims-efficiency metrics show how well ECP and non-ECP claims performed on the administrative tasks of filing a claim, and then allowing or denying it.

FIGURE 10 Average Number of Days to File a Claim

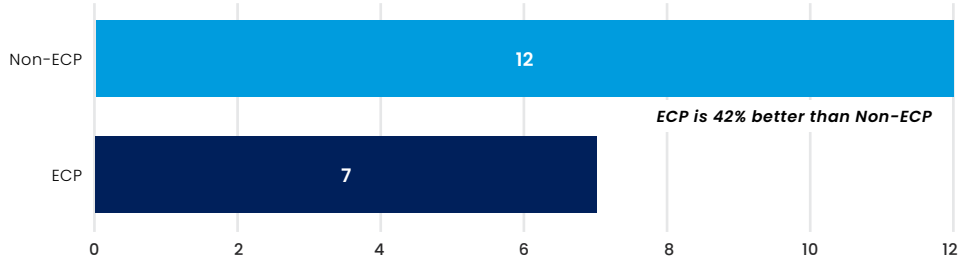
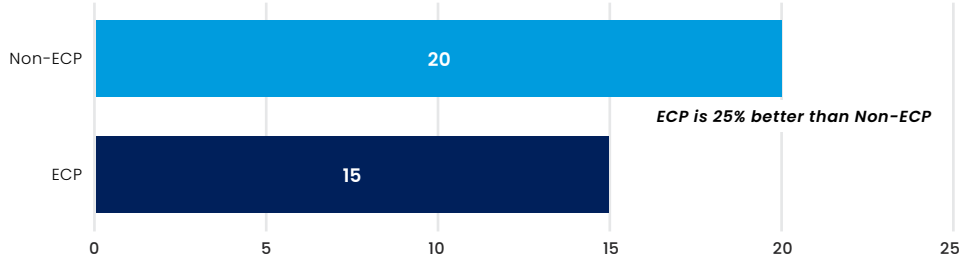


FIGURE 11 Average Number of Days to the First Allow/ Deny Determination



These medical-efficiency metrics show how fast and efficiently ECP and non-ECP delivered care to injured employees. How long did it take before the injured employee saw a provider? How long before the first procedure or surgery?

FIGURE 12 Average Number of Days to the First Provider Visit

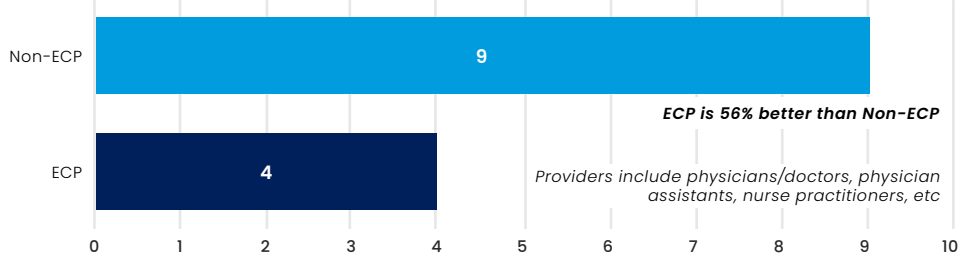


FIGURE 13 Average Number of Days to the First Procedure

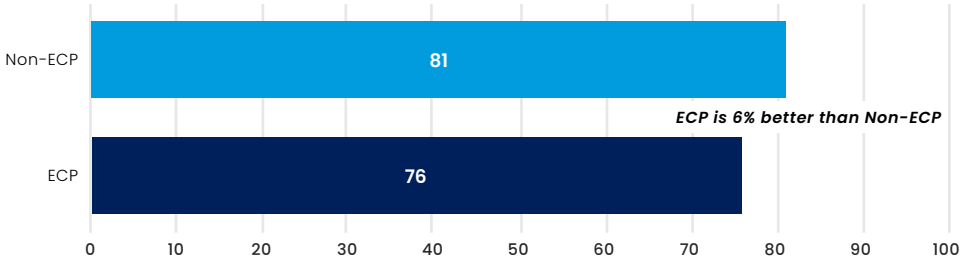
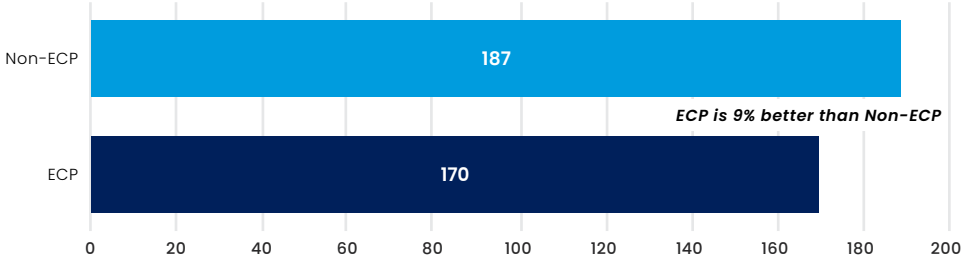


FIGURE 14 Average Number of Days to the First Surgery



$2.1 MILLION IN SAVINGS

Ohio's Bureau of Workers' Compensation would have paid more for these better results, but they paid less — much less.

IntegerHealth calculated the savings from the ECP in two ways. First, the 1,198 ECP claims cost $9,587,800 in medical and lost-time wages. If these ECP claims had been non-ECP claims, how much would they have cost? If more than that total, then the State of Ohio saved money by having these claims in the ECP.

Second, the 1,909 non-ECP claims cost $13,247,500 in medical and lost time wages. If these non-ECP claims had been ECP claims, how much would they have cost? If less than that total, then the State of Ohio spent more money because these claims weren't in the ECP.

These two methods are different ways of looking at the same issue. They are mutually exclusive, not additive. You can have all the claims in ECP and measure the savings by moving the non-ECP claims there; or you can assume that ECP doesn't exist and measure the cost of moving all the ECP claims to non-ECP. You can't do both.

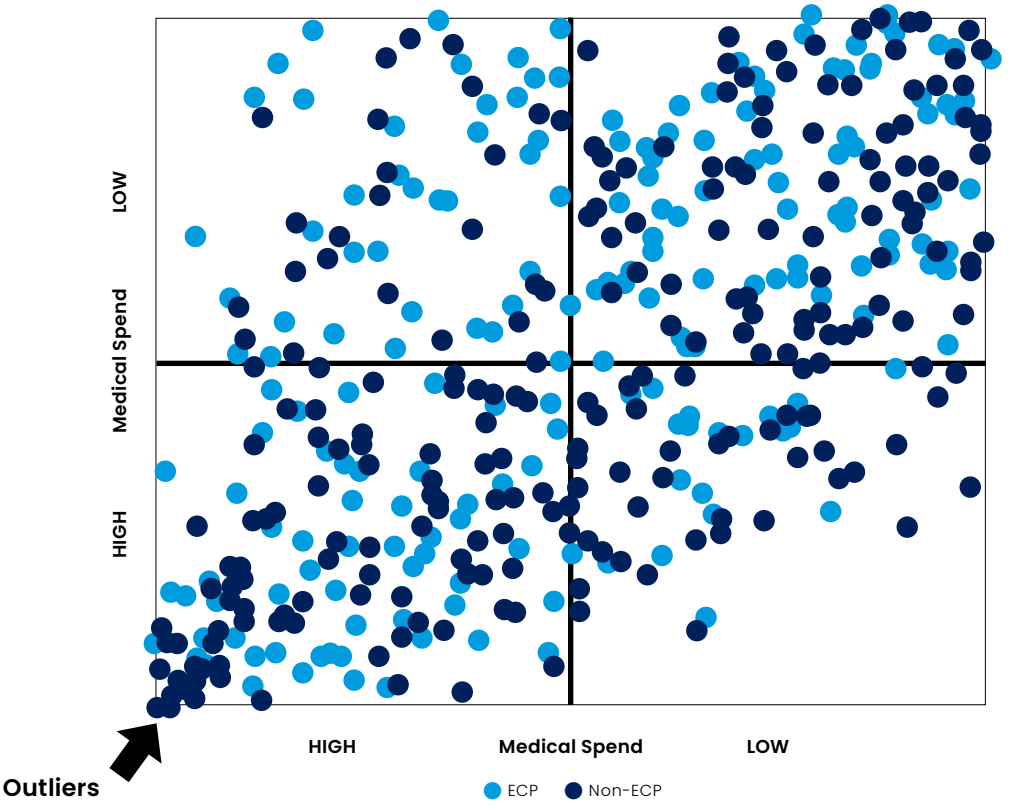
IntegerHealth calculated the potential savings under these two scenarios using the average cost per category, the average cost per category with the outliers capped, and the average cost per category with the outliers excluded. We'll discuss outliers in a moment.

The average of these models indicated a possible savings of $2.1 million (IntegerHealth 2022).

OUTLIERS

Figure 15 shows the major knee injuries with medical and lost-time wages in a quadrant graph (in this case, excluding those major injuries with only another form of indemnity payment). Each blue bubble is an ECP claim, and each dark blue bubble a non-ECP one. The claims are graphed along the horizontal axis according to their medical costs (high on the left and low on the right), and along the vertical axis by their lost-time wages (high on the bottom and low at the top). The best-performing claims are in the upper right quadrant (low medical and low lost-time wages), and the worst-performing ones in the lower left quadrant (high medical and high lost-time wages).

FIGURE 15 Distribution of Outliers



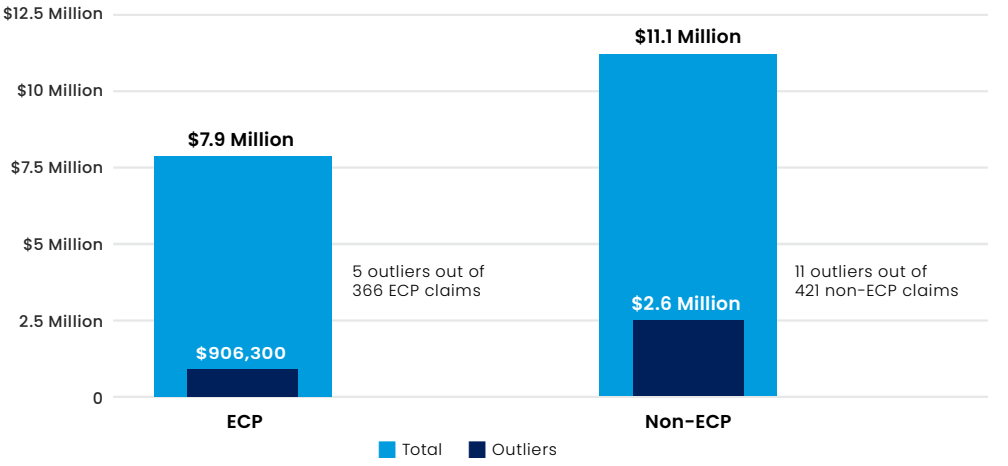
The outliers are in the bottom left corner. So, what are outliers?

Outliers are claims far outside the norm. Including outliers when calculating averages skews the averages higher. Although the average with the outliers will be mathematically correct, it would not be what you would typically expect; much like the difference between the arithmetic mean (i.e., the average) and the median (i.e., the number in the middle when all the numbers are listed sequentially from lowest to highest). Outliers can be defined several ways — sometimes as data three standard deviations above the mean, sometimes as data in the highest

quartile, and sometimes as data exceeding a set amount. IntegerHealth defined outliers as any claim with medical cost or lost-time wages more than $100,000.

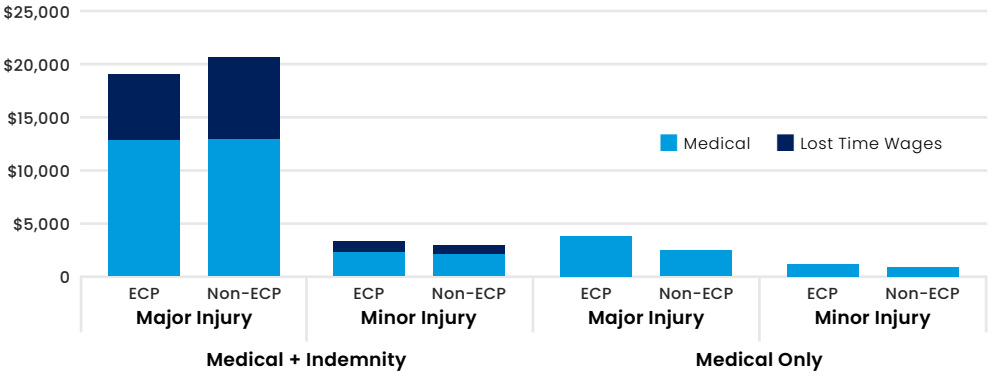
All the outliers were in the major injury with medical and indemnity category. Only 1.4% of ECP injuries in this category were outliers, while 2.6% of the non-ECP claims were. In addition, the average cost of an ECP outlier was $181,300, or 23.0% lower than the average non-ECP outlier of $235,500. Although the data set is not large enough to make a statistical conclusion, another advantage of ECP may be that it is better than non-ECP at both reducing the cost of outlier claims and preventing claims from becoming outliers.

FIGURE 16 Outliers vs. Total Major Injuries – Medical + Indemnity



Outliers are aberrational. They happened, and some will happen in the future. But when using the data to make predictions, the most conservative approach is to exclude them. When excluding outliers, the gap between the average claims cost for major injuries with medical plus indemnity narrowed, although ECP was still 7.5% better than non-ECP.

FIGURE 17 Average Cost with Outliers Removed



Outliers should be evaluated on a case-by-case basis to determine if there are legitimate reasons why they are outliers, such as the presence of multiple comorbidities. When examining the files for the 16 outliers, nine noted some type of behavioral health diagnosis and 10 involved prescribing opioids. Figure 18 is a word cloud that shows the prevalence within the outlier files of various items.

FIGURE 18 The Prevalence of Various Items in Outliers

WHAT WOULD MAKE ECP EVEN BETTER: COMORBIDITIES AND RISK SCORING

If you ask any doctor why they cost more than another doctor, they will always give you the same answer. "Because my patients are sicker." And sometimes they're right.

For example, assume that two employees have identical knee injuries. One of these employees is in their 20s and runs marathons on the weekends. The other is in their 60s, has diabetes and is obese. Even though they have identical knee injuries, we know it's going to take longer, and cost more, to get the obese employee in their 60s with diabetes back to work. If we know about these other conditions — referred to as comorbidities — we can adjust for them by assigning patients risk scores that give doctors credit for treating more complex patients.

Generally, workers' compensation data does not contain information on comorbidities, and the pilot's data did not contain any either. This is a shortcoming when comparing the richness of workers' compensation analysis to that of health plans, which does contain this information. Accordingly, the bureau is considering adding a comorbidity section to its treatment request form with check boxes for the patient's comorbidities, such as cancer, congestive heart failure, chronic obstructive pulmonary disease (COPD), diabetes, hypertension (high blood pressure), obesity and smoking.

With this data, combined with the patient's age and gender, the bureau could calculate risk scores for injured employees. Risk scoring could go a long way in explaining outliers. Outliers on injured employees with high-risk scores — the higher the risk score, the more complex the patient — could be justified. Outliers on injured employees with low ones would warrant scrutiny. In addition, risk scoring the population would level the playing field when comparing physicians. No longer could a doctor say that they cost more because their patients were sicker, as risk scores filter that out.

Two open-source risk-scoring systems demographically appropriate for a working-age population are the Department of Health and Human Services – Hierarchical Condition Categories (HHS-HCC) and the Chronic Illness and Disability Payment System (CDPS). Insurers use HHS-HCC in the Affordable Care Act marketplace. The sicker someone is, the more the government pays the insurance company to insure them. CDPS is used by several Medicaid programs.

Job descriptions and Social Determinants of Health (SDOH) can also augment the risk scores. An injured employee with a desk job may be expected to return to work sooner than one who works in the field. SDOH are social factors that may affect how long an injured employee takes to return to work. SDOH includes attributes such as the employee's finances, food security, access to transportation, housing situation, lack of a family and/or social support network and whether the employee had adverse childhood experiences (ACE). This data could be captured by asking injured employees to complete an SDOH questionnaire.

WHAT'S NEXT?

The bureau expanded the Enhanced Care Program statewide and made the program for knee-only injuries permanent. But there are plenty of other types of workers' compensation injuries that could benefit from similar programs, and the bureau continues to explore ways to improve the workers' compensation system. And the bureau isn't going to keep this a secret but evangelize what it did to drive down costs while improving the quality of care so that others can emulate the ECP and reap similar benefits.

CONCLUSION

Ohio reimagined workers' compensation through its ECP pilot, cutting red tape, eliminating barriers and getting injured employees treated faster. The result: Employees returned to work 30% faster and the State of Ohio saved an estimated $2.1 million.

So how can this benefit your organization? If you supervise a workers' compensation program, consider establishing a program like ECP for your injured employees with knee and other injuries.

And even if you don't, you probably oversee the employee health plan. Take the ECP principles and metrics and apply them to it. For example, establish a narrow

network within your health plan's overall provider network composed of physicians seeing, treating and getting employees back to work faster. Incentivize your employees and their dependents to go to these physicians by decreasing or eliminating their copays and deductibles when they do. Your health plan also has case managers working with chronically ill and high-cost claimants. Those folks look to these case managers for guidance on which specialists and surgeons to see. Make sure the case managers know who are high-performing specialists and surgeons (Roloff 2020). You'll be glad you did.

ABOUT THE AUTHORS

John Annarino (john.a.2@bwc.state.oh.us) is the chief medical and health officer at the State of Ohio's Bureau of Workers' Compensation (BWC). Annarino leads BWC's healthcare reforms, coordinating with medical staff and senior BWC management to create a cutting-edge healthcare delivery system. He works with the chiefs of medical services and compliance, medical operations, and the medical director to lead BWC's medical division. Annarino is also a lawyer.

Deborah Kroninger was the chief of medical operations at the Ohio BWC, managing the business areas that coordinate its vocational rehabilitation program, disability evaluator panel services, provider relations, transitional work grant and bonus programs, alternative dispute resolution, pharmacy management and nurse support.

Bliss Dickerson is the director of provider outreach and engagement at the Ohio BWC, working with Enhanced Care Program (ECP) physicians of record to help ensure they understand the program and are implementing the program parameters. She also leads BWC's efforts to recruit ECP physicians. Dickerson is a registered nurse and has focused her career on occupational medicine.

Freddie Johnson is the chief of medical services and compliance at the Ohio BWC, managing various business areas and strategies necessary to support the administration of the Health Partnership Program. He negotiates and manages the 10 managed care organization (MCO) contracts, as well as maintains and updates Ohio's workers' compensation benefit and fee reimbursement plans. Johnson is also a lawyer.

Scott Roloff (sroloff@integerhealth.com) is the president of IntegerHealth Technologies, which combines advanced analytics with medical expertise to quantify healthcare outcomes for health plans, workers' compensation programs and wellness programs to help drive down costs and improve care. Roloff is both a CPA and a lawyer.

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