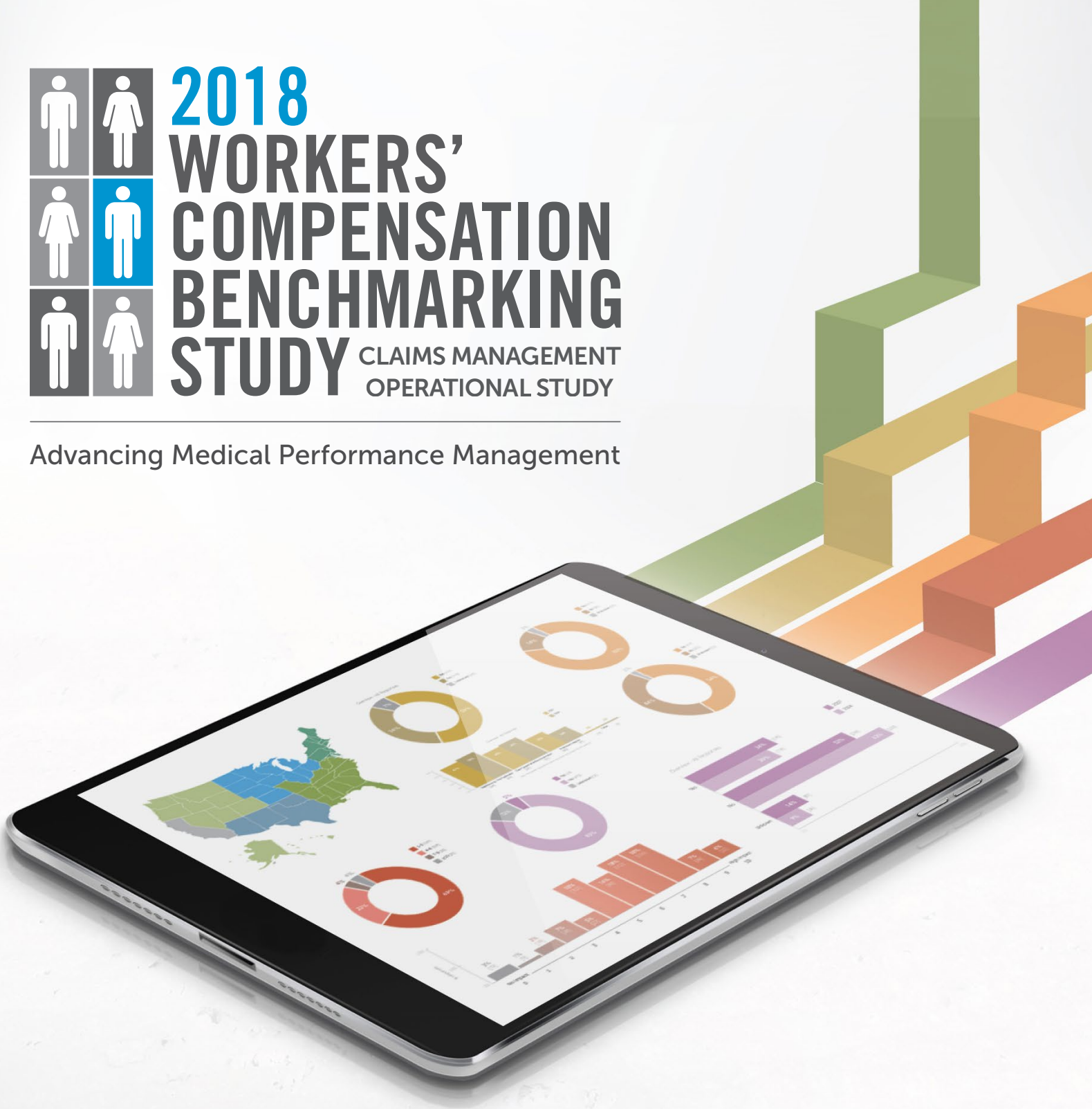
2018 WORKERS' COMPENSATION BENCHMARKING STUDY

CLAIMS MANAGEMENT OPERATIONAL STUDY

Advancing Medical Performance Management



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Rising Medical Solutions

RISING

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Preface

About the Study

The Workers' Compensation Benchmarking Study is a national research program that examines the complex forces impacting claims management in workers' compensation today. The study's mission is to advocate for the advancement of claims management by providing both quantitative and qualitative research that allows organizations to evaluate priorities, hurdles, and strategies amongst their peers. Conceived by Rising Medical Solutions (Rising), the study's impetus evolved from various conversations Rising had with industry executives about the gap in available research focusing on how claims organizations address daily operational challenges.

Today, the ongoing study program is a collaboration of workers' compensation leaders who represent diverse perspectives and share a commitment to providing meaningful information about claims management trends and best opportunities for advancement. Recognizing the need for an unbiased approach, the study is guided by an independent Principal Researcher and an Advisory Council of industry experts whose involvement is critical to maintaining a framework that produces impartial and compelling research.

About the Study Director & Publisher, Rising Medical Solutions

Rising is a national medical cost containment and care management company serving payers of medical claims in the workers' compensation, auto, liability, and group health markets. Rising spearheaded the study idea and leads the logistical, project management, industry outreach, and publication aspects of the effort. For study inquiries, please contact VP & Study Program Director Rachel Fikes at wcbenchmark@risingms.com.

About the Principal Researcher & Study Report Author, Denise Zoe Algire, MBA, RN, COHN-S/CM, FAAOHN

Denise Zoe Algire is the Director of Risk Initiatives & National Medical Director for Albertsons Companies. She is a nationally recognized expert in managed care and integrated disability management. She is board certified in occupational and environmental health and is a fellow of the American Association of Occupational & Environmental Health Nurses. Bringing more than 20 years of industry experience, her expertise includes claim operations, medical management, enterprise risk management, and healthcare practice management.

Study Advisory Council / Research Participants

Essential to the study program and research is its Advisory Council, comprised of nearly 20 workers' compensation executives who represent national and regional carriers, employers, third party administrators, brokerages, and industry consultancies.

Since 2013, their varied perspectives have guided the study's continued efforts to examine some of the most significant operational challenges facing claims organizations today. From the formation of research strategies to the interpretation of results, the Council has provided critical expertise throughout this endeavor.

In 2018, members of the Council participated in both think-tank sessions as well as this year's qualitative, focus group research. Among those distinguished advisors we thank for their time and commitment are:

- Denise Zoe Algire | Director of Risk Initiatives & National Medical Director | **Albertsons Companies**
- Raymond Jacobsen | Senior Managing Director | **AON Benfield**
- Daniel T. Holden | Risk Operations Manager | **BBSI**
- Marcos Iglesias, MD | Senior Vice President, Chief Medical Officer | **Broadspire**
- Rich Cangiolosi | Vice President, Western Region | **Cannon Cochran Management Services, Inc. (CCMSI)**
- Trecia Sigle | Vice President, Enterprise TPA & Multinational Claim | **CNA**
- Kelly Kuri | Claims Manager | **Frank Winston Crum Insurance**
- Helen Weber | Assistant Vice President, Head of Medical Strategy | **The Hanover Insurance Group, Inc.**
- Adam Seidner, MD, MPH | Chief Medical Officer | **The Hartford**
- Scott Emery | Senior Director, Claims | **Markel**
- Tom Stark | Technical Director, Workers' Compensation | **Nationwide Insurance**
- Tom McCauley | Owner & Consultant | **Networks by Design**
- Darrell Brown | Chief Claims Officer | **Sedgwick**
- John Smolk | Principal Manager, Workers' Compensation | **Southern California Edison**
- Jim Kerr | Vice President of Claims Operations | **TRISTAR**
- David Price | Vice President, Risk Management | **UMR, Inc.**
- Linda Butler | Director, Claims Management | **Walt Disney World Resort**
- Brian Trick | Senior Manager of Claims | **Wegmans Food Markets, Inc.**
- Kyle Cato | Associate Risk Manager, Workers' Compensation & General Liability Claims | **Williams-Sonoma, Inc.**

Invited Research Participants & Acknowledgments

In addition to our Advisory Council members, this year's focus group research captured the insights, guidance, and experiences of a broader group of industry executives. The depth of their perspectives was vital to the study's qualitative research endeavors. Our many thanks to these individuals for contributing their considerable expertise towards advancing claims management in the industry.

- Melissa Dunn | Regional Claims Advocacy Leader | **Arthur J. Gallagher & Co.**
- David McGhee | Vice President, Workers' Compensation | **BETA Healthcare Group**
- Debra Kane | Vice President, Commercial Claim – Workers' Compensation | **CNA**
- Jill Dulich | Claims & Operations Manager | **California Self-Insurers' Security Fund**
- Christopher Schaffer | CEO – Insurance Support Services | **Charles Taylor Americas**
- Suzanne M. Emmet | Senior Vice President, Claims | **Eastern Alliance Insurance Group**
- Jeffrey Austin White | Senior Vice President, Product Manager – Workers' Compensation | **Gallagher Bassett**
- Michele Fairclough | Medical Services Director | **Montana State Fund**
- Mindy Roller, Esq. | Deputy Chief, Workers' Compensation Division | **New York City Law Department**
- Janine Kral | Vice President, Risk Management | **Nordstrom**
- Freddie L. Johnson, JD, MPA | Chief of Medical Services & Compliance Officer | **Ohio Bureau of Workers' Compensation**
- Terrence B. Welsh, MD | Chief Medical Officer | **Ohio Bureau of Workers' Compensation**
- Thomas Denberg, MD | Senior Medical Director | **Pinnacol Assurance**
- Tony Brecunier | Vice President, Workers' Compensation Claims | **SECURA Insurance Companies**
- Noreen Olson | manager, claims | **Starbucks**
- Karen Olson, MD | Medical Director | **Summit Consulting LLC**
- Kim Haugaard | Senior Vice President, Policyholder Services | **Texas Mutual Insurance Company**
- Barry Bloom | Principal | **The bdb Group**
- Tom Wiese | Vice President, Claims | **The MEMIC Group**
- Mary Ann Lubeskie | Vice President of Managed Care | **TRISTAR**
- Jill Rosenthal, MD | Senior Vice President, Chief Medical Officer | **Zenith Insurance**

We would also like to acknowledge the industry leaders and organizations that provided further counsel during the Study Report review, as well as those who have heightened the industry's awareness of the study research. Thank you for your invaluable support:

- Dan Reynolds | Editor-in-Chief, Risk & Insurance
- Pamela Highsmith-Johnson, BSN, RN,CCM | Director of Case Management, CNA
- Peter Rousmaniere | Risk Management Consultant & Writer
- Randall Lea, MD | Orthopedic Surgeon & Senior Clinical Research Fellow, WCRI
- Roberto Ceniceros | Senior Editor, Risk & Insurance & Chair of the National Workers' Compensation and Disability Conference & Expo
- William Wilt, FCAS, CFA | President, Assured Research

Introduction

Since the Workers' Compensation Benchmarking Study launched in 2013, claims leaders have consistently ranked medical management as the core competency most critical to claim outcomes. With medical costs averaging over 60 percent of claims costs in many jurisdictions,[1] the study's Advisory Council recommended the 2018 study further investigate what claims payers are doing to surmount this top industry challenge.

As one of the preeminent threats to effective claims management and to the American economy, the 2018 Study focuses *solely* on Medical Performance Management.

Historically, the study has focused on four key areas of claims operational performance: core competencies, talent development and retention, technology and data, and medical performance management. This year, however, the study focuses *only* on medical performance management and its impact on claims operations. The decision was based on feedback from claims professionals who have asked exactly *how* to overcome the widely-faced medical performance management challenges identified in prior studies. These challenges include putting into play key best practices, which include employing provider performance measures, leveraging outcome-based networks, and implementing value-based payment models. Other best practices involve integrating behavioral health into workers' compensation programs and measuring the success and return on investment (ROI) of various medical interventions.

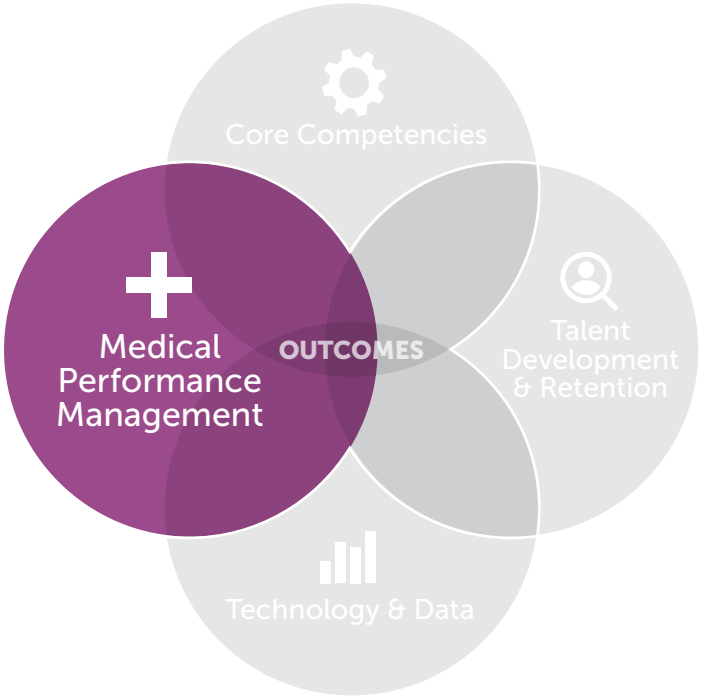
4 Major Drivers of Claim Outcomes

Core Competencies
Building a strong foundation by mastering and measuring things that matter.

Talent Development & Retention
Enhancing organizational results by investing in claims management talent development.

Technology & Data
Changing the future of claims by effectively leveraging analytics and workflow automation to enhance individual judgment and organizational focus.

Medical Performance Management
Leveraging the changing landscape through medical management strategies focused on healthcare quality and outcomes.



Now in its sixth year, the Workers' Compensation Benchmarking Study takes into account the opinions of over 1,700 claims leaders who described, via online surveys, the current state of claims management on 70-plus data points. For the 2018 study, over 40 industry executives examine these prior study results to identify opportunities for medical performance management and claims operational advancement. Through think-tank sessions and focus group research, qualitative interviews were conducted to gather their insights, collaborations, and guidance on the most potent and realistic claims operational strategies that should be considered by payer organizations over the next two to three years.

Central to the 2018 qualitative effort was a survey of these executives on the industry's medical management challenges they felt were critical to examine during the research exercise. Below are five issues they ranked as pressing to discuss. Please see Appendix A for full survey results.

SURVEY RESULTS

Medical Performance Management Issues Ranked Critical for 2018 Focus Group Research

- Prior studies consistently rank medical management as the most critical core competency to claim outcomes. What are your medical performance management priorities now and in the next two to three years? What have you done that works?
- Medical severity due to macroeconomic and social factors, such as the aging workforce, the opioid epidemic, mental health, obesity, and diabetes, has a significant impact on claims. What resources, strategies, or data are organizations using to identify, predict, or manage these issues?
- Prior studies identify nurse case management, return-to-work services, and nurse / claims triage as the top three medical management programs most critical to claim outcomes. How / when are these resources utilized? What are other disruptive ways to deploy these programs? How are organizations measuring outcomes to support ROI / impact?
- The workers' compensation industry talks about quality and outcome-based provider networks, yet many still look for discounts, including the traditional metrics with "savings" below fee schedule methodologies. Are quality and provider outcomes important? If so, how has your organization leveraged quality and outcome-based provider networks? What metrics are you using to measure provider quality and outcomes and/or network results?
- The workers' compensation industry is focused on advocacy-based claims models, described as an employee-centric customer service claims model that focuses on employee engagement during the injury recovery process, removes adversarial obstacles, makes access to benefits simple, builds trust, and holds the organization accountable to metrics that go beyond cost containment. How are organizations integrating medical management into advocacy-based claims models? What initiatives have you implemented, and how are you measuring success?

Methodology

The 2018 study approach was formulated through facilitated think-tank sessions with the Principal Researcher and the Advisory Council Members. This report is based on the qualitative research conducted through focus groups and interviews with 40-plus industry executives from every major type of workers' compensation payer organization, including employers, insurance carriers, third party administrators (TPA), governmental entities, state funds, as well as brokerage and industry consultants.

The study convened two focus groups of industry executive participants. Participants were selected by direct invitation from the Advisory Council Members and study architects. The participants were grouped by role in the core functional areas of medical and claims management as well as to ensure an equitable distribution of industry payer organization type (employer, insurance carrier, TPA, governmental entity, state fund, as well as brokerage and industry consultants). Participants were segmented into claims leaders and clinicians / managed care leaders to identify priorities and approach commonalities, as well as medical performance management variances which may expose gaps that need to be bridged to improve outcomes.

Prior to the focus group meetings, industry executives participated in a confidential, online survey to prioritize medical management challenges and opportunities most critical to discuss. The survey tool structure and questions were developed by the Principal Researcher, and formalized as problem statements identified from the 2013 to 2017 studies as well as priorities identified by the Advisory Council Members during think-tank sessions. The survey questions were organized across the study's index of Medical Performance Management.

The focus groups were led by subject matter expert moderators utilizing a consistent discussion framework tool developed by the Principal Researcher. Focus group content was organized using the problem statements identified by the industry executives in the survey as most critical to discuss. Focus group participants discussed their experiences, perspectives, insights, and opinions, as well as goals / desired outcomes, challenges / barriers, and industry opportunities / possible solutions regarding different efforts related to the problem statements.

The focus groups produced in-depth, qualitative research data related to medical performance management within claims operations. The use of focus groups increases candor, probe, and the thinking behind participants' opinions and can generate data that would otherwise be inaccessible without the interaction of group participants.

The Principal Researcher completed the qualitative data validation and analysis, as well as authored this Study Report.

The Report is based on the interpretation and compilation of the qualitative research. Each study participant's views are not necessarily reflected in every conclusion.

TWO FOCUS GROUPS

Claims Executive Focus Group | **Medical Executive Focus Group**

Segmentation Helped Identify Medical Performance Management:

Approach
(Commonalities / Differences)

Priorities
(Commonalities / Differences)

Areas for Bridging the Gap

Executive Summary

Employer costs for workers' compensation exceed $94 billion annually, with benefits extending to more than 135 million workers.[2] The workers' compensation industry faces numerous, complex operational challenges that organizations must overcome to remain competitive. One of the greatest challenges is the unprecedented impact of healthcare costs. It has been characterized as the preeminent long-term threat to the economy and the competitiveness of American business. This imperative is driving intense focus on medical performance management by the study Advisory Council.

During the 2018 study's focus group research, industry executives examined key issues influencing medical performance management. The fundamental question the study undertakes is *how* organizations turn the challenges identified in the prior studies into solutions and action.

This Report summarizes the greatest impact opportunities and most potent strategies that payers may consider over the next two to three years. These actionable strategies were identified by industry executives through qualitative research and are based on their collective experiences, perspectives, insights, and opinions. A summary of the detailed strategies are presented below:

Greatest Impact Opportunities – Key Strategies

- **Change success metrics from "volume discounts" to "value."** To move from volume to value, organizations must start internally by fostering organizational alignment around quality and outcomes. This requires changing the longstanding practice of measuring program success based on percentage of savings metrics.
- **Measure outcomes that are aligned with the Triple Aim.** The "Triple Aim" framework was developed by the Institute for Healthcare Improvement (IHI) and outlines an approach to optimize healthcare performance and outcomes. To truly improve outcomes, metrics must be patient-centered, including improvements in function, productivity, and reduced total cost of risk. Organizations must embrace all three dimensions. Focusing on quality process measures, reducing costs (or reducing fee-for-service ratios), or decreasing utilization alone will not produce the necessary impact.
- **Leverage existing tools and available data applicable to measure provider performance and outcomes.** The workers' compensation industry has the means. Utilize provider quality and outcome measures based on treatment within evidence-based medicine guidelines, benchmarking return-to-work outcomes, improved function, coordination of care, and patient satisfaction. Valid provider performance measures can significantly improve the quality of care and outcomes across the industry. The primary objective in assessing provider performance is to ensure the highest quality of care for workers through transparency, accountability, and aligned incentives.
- **Deploy wellness coaching / personal training tools to improve employee health.** Industry executives report the need to leverage more holistic solutions to truly impact comorbidities and employee resilience. The focus groups report a collective focus on health and wellness, as well as alternative care delivery models. Use disruptive solutions to augment traditional medical management programs. Consider partnering with wellness service providers and/or health plan resources such as disease management, health coaching / personal training, and employee assistance programs (EAP) to better manage comorbidities and improve claim outcomes.

Cont'd

- **Consider diverse tools to improve stakeholder communication.** Proactive communication is critical to facilitating timely care and return-to-work. Industry executives report using multiple communication tools (e.g. mobile apps, text messaging, portals) for workers and providers to access claim details and submit documents (e.g. return-to-work notices, treatment requests). Additionally, a large employer reports using mobile video communication tools – like FaceTime – to meet with employees and providers in real-time, as well as to approve treatment decisions on the spot.
- **Utilize technology to support provider access and speed to care.** The focus groups report several emerging technology solutions that offer alternative care delivery models, such as remote / app-based physical therapy and health coaching, use of drones, and telehealth. Utilizing alternative delivery models allows organizations to deliver care to employees in remote areas, as well as based on their preferences.
- **Leverage data and advanced technology solutions to predict and proactively manage claim risk factors, including comorbidities.** Organizations should leverage predictive analytics throughout the claim lifecycle with actionable intelligence – like prescriptive analytics – to manage multiple, complex claim risk factors. Examine the use of artificial intelligence to mine large data sets, including medical records.
- **Integrate mental health programs into medical management programs.** Consider leveraging EAP programs, cognitive behavioral health, and mindfulness solutions as part of an integrated medical management solution. To raise awareness, educate claims and medical management professionals about mental health conditions and solutions, as well as known and unconscious bias toward mental health issues by claims professionals and employers.
- **Advance a culture of advocacy throughout medical management programs.** Utilize ongoing, consistent communication in program goals and objectives in order to engage internal and external claims and medical management stakeholders in claims advocacy. Messaging should focus on advocacy as a continuous, holistic component of the business strategy. Incorporate Key Performance Indicators (KPIs) focused on speed to decision, such as claim acceptance, delivering healthcare services and benefits faster, employee-centered outcomes / satisfaction, as well as reduced litigation and claim duration.

Operational Challenge
Medical Performance Management

Industry imperative: intense focus on medical performance management

Medical coverage is the most expensive benefit for American employers and healthcare in the US is the costliest worldwide, accounting for more than 17 percent of the gross domestic product with estimates that percentage will reach 20 percent by 2026. National healthcare spending is projected to grow at an average rate of 5.5 percent per year for 2017–2026 and to reach $5.7 trillion by 2026.[3,4] At the same time, aging populations and increased longevity, coupled with comorbidities, have become a national challenge significantly impacting health outcomes.

On the workers' compensation side, average claim severity continues to rise, with medical lost-time claim costs rising faster (+175 percent) than the Personal Health Care Price Index (1997–2017p) (+61 percent) over the same period. The National Council on Compensation Insurance (NCCI) estimates that 2017 average medical lost-time claim severity is four percent higher than the corresponding 2016 value.[5] (Note: Effective Q3 2017, NCCI began using the Personal Health Care (PHC) deflator to measure medical inflation.)

The cost of medical care continues to dominate national health care trends as well as total workers' compensation claim costs. The 2014 and 2017 study results reflect the industry's focus is on the operational areas most likely to influence overall claim costs, consistently ranking medical management most critical to claim outcomes (see Table 1). Yet, only 74 percent of claims organizations measure best practices within the medical management core competency according to the 2017 study.

Top 3 Core Competencies Ranked Most Critical to Claim Outcomes

1. Medical Management
2. Disability / Return-to-Work Management
3. Compensability Investigations

Source: 2014 & 2017 Workers' Compensation Benchmarking Studies

Organizations now need to center their attention on what they can do to confront rising medical severity. This underscores the Advisory Council's recommendation to focus the 2018 study exclusively on medical performance management.

Table 1 Survey Question: *Please rank in the order of highest priority the core competencies most critical to claim outcomes, with 1 being the "highest priority" and 10 being the "lower priority."* [572 responses]

Answer	Overall Rank	Mean
Medical Management	1	3.06
Disability / RTW Management	2	3.08
Compensability Investigations	3	3.65
Claim Resolution	4	4.28
Case Reserving	5	5.65
Litigation Management	6	5.99
Oversight Governance / Supervisory Oversight	7	6.47
Bill Review	8	7.03
Fraud & Abuse Detection	9	7.23
Vocational Rehabilitation	10	8.56

Source: 2017 Workers' Compensation Benchmarking Study

Top Industry Priority - Employee Wellbeing Initiatives

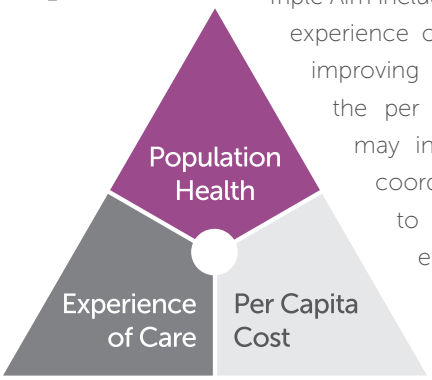
Discussed by: Claims Executive Focus Group | Medical Executive Focus Group

Workers' Compensation Triple Aim

During the 2018 study's qualitative research exercise, industry executives examined key issues impacting medical performance management, namely how to: measure provider outcomes, utilize value-based payment models, examine severity due to macroeconomic factors, leverage medical management in advocacy-based claims models, and utilize medical management resources more effectively. Additionally, participants discussed medical performance management priorities and initiatives that have yielded positive outcomes.

Both the Claims and Medical Management industry executives examined discussion topic number one (described on the right) independently during the focus group exercise. Surprisingly, the focus groups presented an uncompromising, aligned vision that could be characterized as the *workers' compensation industry's Triple Aim*. The focus groups' alignment centered around three common goals: investing in health outcomes, encouraging employee engagement and empowerment, and promoting population health and injury prevention.

The **IHI Triple Aim**



The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing healthcare performance and outcomes. The Triple Aim includes three dimensions: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of care.[6] These innovations may include, but are not limited to, increased coordination of care, improved and timely access to appropriate care, and patient-centered education. Both payers and providers targeting Triple Aim goals are looking to shift away from fee-for-service care and toward risk-based contracting.

Medical Performance Management

Discussion Topic #1

Prior studies consistently rank medical management as the most critical core competency to claim outcomes. What are your medical performance management priorities now and in the next two to three years? What have you done that works?

Key Considerations:

- With so many critical areas of medical management, how do organizations identify priorities?
- What data elements and/or resources are needed to identify and support priorities?
- Are there internal / external factors that influence priorities?

Improved outcomes require improving the health of patients and the patient experience, as well as reducing costs. However, what constitutes an improvement in workers' compensation outcomes is more complex. In most healthcare settings today, as well as within the workers' compensation industry, no one entity is accountable for all three dimensions of the Triple Aim. To truly improve outcomes, the workers' compensation industry must collectively embrace all three dimensions. Focusing on quality process measures, reducing costs (or reducing fee-for-service ratios), or decreasing utilization alone will not produce the necessary impact. Organizations should consider alternative models including: accountable care organizations (ACOs), bundled payments, new models of primary care (e.g. patient-centered medical homes), and sanctions for avoidable events and/or risk of harm.

In workers' compensation, two well-known examples of patient-centered primary care models are Kaiser On-the-Job and Washington Labor & Industries – Centers of Occupational Health and Education (COHEs). COHEs work with medical providers, employers, and workers in a community-based program designed to ensure timely, effective, and coordinated services to improve worker outcomes and reduce disability by training providers and coordinating care.[7]

Goals / Desired Outcomes Identified by Industry Executives for Discussion Topic #1

- Improve the quality of care and outcomes for employees through employee / patient-centered outcomes.
- Return employees to health and wellness with the best achievable outcome.
- Focus on healthy workforce / population health-centered outcomes.
- Sustain return-to-work by successfully keeping employees at work after the injury / illness.
- Encourage employee engagement / satisfaction.
- Recognize the impact of employee biopsychosocial factors (biological, psychological, and social) on worker health / wholeness.

Greatest Impact Opportunities – Key Strategies

Industry Executives recommend the following medical performance management priorities that organizations should consider in the next two to three years.

1. **Begin with the end in mind.** Define the quantitative and qualitative outcomes that your organization wants to achieve. To operationalize outcome-based measures, reverse engineer performance measures. Start with the ultimate goals and desired outcomes, then, identify the activities (levers) that drive the desired outcomes to ensure an appropriate balance between quantitative and qualitative metrics. For example, a quantitative measure might be the identification of modified work availability before lost time occurs and the time lag in identifying modified duty availability to actual return-to-work. Qualitative measures might be the evaluation of effective communication with key stakeholders, or appropriate instructions / management of specialized return-to-work resources.

2. **Leverage universal provider scorecards, and share / publish results.** Define, measure, and ensure quality medical care and outcomes, including employee / patient-centered outcomes. Measure provider practice patterns / outcomes against evidence-based medicine. Ensure transparency of provider performance (e.g. Texas Department of Insurance's model of publishing annual provider network "scorecards"). Include and engage providers in the design and ongoing evaluation of provider scorecard methodology.

3. **Develop formal provider education and communication strategy.** Utilize a multipronged approach to provider education, including a focus on function and stay-at-work / return-to-work, the use of evidence-based medicine as a tool for optimal care, as well as patient education and empowerment. Ensure providers understand the total cost of care / claims, performance and quality metrics, and how they and/or their referrals impact outcomes. Consider the use of a provider liaison, internally or externally through vendor / consultant partners, to facilitate ongoing provider education and communication.

4. **Enhance employee education and engagement.** Focus on empowering employees to understand the importance of being educated consumers of their health and wellness, the importance and role of evidence-based medicine, the advantages of centers of excellence, and the critical function of stay-at-work / return-to-work in their recovery process. Encourage employees to be an active participant in their health care decisions and identifying return-to-work solutions.

5. **Enhance employer education.** Educate employers about advocacy, empathy, and the importance of ongoing employee communication, particularly after an injury occurs or when an employee is off work. Develop communication tools that can be easily leveraged by managers / supervisors that show care and concern for employees after an injury or illness.

6. **Utilize technology to identify and drive medical performance management priorities.** Leverage predictive modeling and prescriptive analytics to improve operational efficiency and medical performance management resource deployment and allocation. Take predictive modeling to the next level by integrating prescriptive analytics to identify optimal activities / interventions to achieve desired outcomes.

7. **Leverage technology to enhance employee resilience.** Improve employee wellbeing by utilizing tools and apps to engage workers in wellness, disease management, injury / illness prevention and recovery, as well as health education and/or health risk assessments. Consider pre-loss and post-loss opportunities to engage employees in proactive health management through identified communication preferences, such as telemedicine, health coaching, text messaging and/or apps.

Leveraging Provider & Quality Outcome Measures

Discussed by: Medical Executive Focus Group

What is quality?

Measuring provider performance is fundamental to improving the value and quality of healthcare. What is quality? The Institute of Medicine defines health care quality as "the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[8] According to The New England Journal of Medicine, patients receive the correct diagnosis and care only 55 percent of the time. Wide variations in quality, access, and outcomes continue due to chronic underuse, overuse, and misuse of services.[9] Valid provider performance measures have the potential to significantly improve the quality of care and outcomes across the industry. The primary objective in assessing provider performance is to ensure the highest quality care for workers through transparency, accountability, and aligned incentives. This requires a coordinated strategy among stakeholders for defining, collecting, and analyzing performance data.

On the group health side, hundreds of clinical performance measures have been developed by private and public sector groups – all without consensus among the medical community, insurers, or purchasers.[10] This has created a significant burden for providers and confusion among consumers. While consumers often associate quality with price, Americans have the world's most expensive health care system, yet have disproportionately lower quality outcomes.[11] To improve outcomes and control costs, payers are increasingly using metrics to rank providers and health care organizations, as well as to structure payment models. To be successful, it is critical that payers collaborate with the medical community in developing meaningful, evidence-based quality and outcome measures.

The 2017 study results indicate that only 34 percent of organizations measure provider performance and outcomes, a modest improvement from the 2014 study (see Figure 1). Of the organizations that reported measuring provider performance, less than half share the results with providers, an opportunity and important feature to drive collaborative change. The 2017 study results also indicate higher performing organizations demonstrate more frequent use of provider performance and outcome measures.

During the 2018 study's qualitative research exercise, industry executives examined how organizations are leveraging provider quality and outcomes, as well as utilizing value-based payment models.

Medical Performance Management

Discussion Topic #2

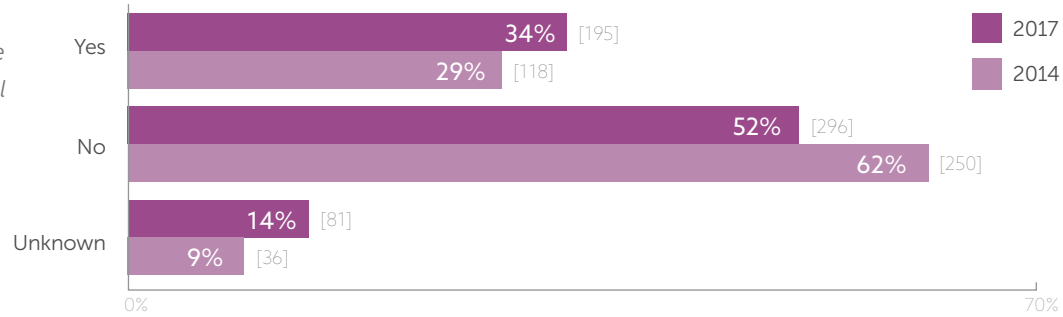
The workers' compensation industry talks about quality and outcome-based provider networks, yet many still look for discounts, including the traditional metrics with "savings" below fee schedule methodologies.

Are quality and provider outcomes important? If so, how has your organization leveraged quality and outcome-based provider networks? What metrics are you using to measure provider quality and outcomes and/or network results?

Key Considerations:

- How are organizations using provider quality and outcome measures to drive the best claim performance?
- How are organizations currently utilizing, or plan to utilize value-based payment models in the future?
- How do organizations leverage qualitative and quantitative data?
- Have organizations leveraged other resources, such as AHRQ, NCQA, HEDIS, CMS Star Ratings, and standardized core quality measures (CQMs)?
- Do organizations really care about quality and healthcare outcomes, or is it just window dressing?

Figure 1 Survey Question: *Does your organization use measures to gauge medical provider outcomes / performance?* [572 responses]



Source: 2017 Workers' Compensation Benchmarking Study

Measure outcomes that are aligned with the Triple Aim

One of the obstacles identified by industry executives is that metrics may be chosen because they are easy to measure rather than being impactful or evidence-based, such as the percentage of savings calculations often utilized in workers' compensation. The Institute of Medicine has warned against using easily obtained process measures as quality indicators, because achieving them may not yield meaningful outcomes.[12] Stakeholders should measure outcomes that are aligned with the Triple Aim, are patient-centered, and are important to employers, including improvements in *function, productivity, and reduced total cost of risk*.

> Stakeholders should measure outcomes that are aligned with the Triple Aim, are patient-centered, and are important to employers, including improvements in function, productivity, and reduced total cost of risk.

Measuring quality aims to empower providers and consumers with information that supports the overall delivery and coordination of care, and ultimately supports payment systems that reward providers for improved care, rather than simply paying based on service volume.

In the 2016 study, participants ranked return-to-work outcomes, patient functional outcomes, and clinical quality metrics as the provider measures most critical to claim outcomes (see Table 2). This suggests the divide between group health and workers' compensation in terms of a "quality focus" is not as wide as previously thought. It also suggests that workers' compensation claims organizations *understand* the importance of Triple Aim principles, though consistent execution of these tenets is still an opportunity area for the industry.

Table 2 Survey Question: *Considering the following medical provider quality / outcome measures, please rank in the order of highest priority the measures most critical to claim outcomes, with 1 being the "highest priority" and 10 being the "lower priority."* [492 responses]

Answer	Overall Rank	Mean
Return-to-Work Outcomes Measure medical provider disability management outcomes against national benchmark data	1	3.08
Patient Functional Outcomes Evaluate injured workers' health status and function as a result of the care they received	2	4.30
Clinical Quality Measure provider quality by adherence to Evidence-Based Medicine (EBM) Guidelines	3	4.71
Frequency & Duration of Medical Treatment Frequency and duration of treatment by injury / diagnosis compared to peers	4	4.71
Coordination of Care Effective communication / coordination across healthcare system; timely referral / coordination across referral sources	5	4.83
Patient Satisfaction Injured worker satisfaction with their medical care as an indicator of provider quality and outcomes	6	5.52
Total Cost of Care Total claim cost per episode of care / Diagnosis-Related Group (DRG)	7	6.31
Administrative Efficiency Quality of documentation and timely submission of reports	8	6.67
Risk of Harm Intended or unintended physical or psychiatric injury resulting from a pattern(s) of low quality care	9	7.18
Litigation Rate Provider's association with litigated claims compared to peer providers in the same geographic area	10	7.69

Source: 2016 Workers' Compensation Benchmarking Study

Goals / Desired Outcomes Identified by Industry Executives for Discussion Topic #2

- Align incentives across stakeholders.
- Focus on quality and outcomes, remove discount metrics.
- Measure quality across the care continuum (physician, physical / occupational therapy, pharmacy, in-patient and outpatient hospital services, etc.).
- Utilize clinically meaningful, patient-centered outcomes.
- Leverage metrics that are supported by evidence-based medicine linked to improved outcomes.
- Drive transparency in quality and outcome metrics, including data, total costs, and how providers will be measured.
- Develop consistency in metrics across payer types.

Greatest Impact Opportunities – Key Strategies

Industry Executives highlight the following recommendations / considerations for measuring provider performance and outcomes.

1. **Leverage existing tools and available data applicable to measure provider performance and outcomes.** The workers' compensation industry has the means. Utilize provider quality and outcome measures based on treatment within evidence-based medicine guidelines, benchmarking return-to-work outcomes, improved function, coordination of care, and patient satisfaction.

2. **Utilize risk adjustment methodology.** Risk adjustment is particularly important for outcome measures because outcomes are driven, in part, by factors such as age, medical history, comorbidities , and geography. Provider performance and outcome measures must be adaptable based on geography, patient population, severity, and other risk factors. Available resources, such as the Official Disability Guidelines (ODG)[13] or MDGuidelines,[14] include risk adjustment calculators that can be utilized on a case by case basis or in aggregate.

3. **Ensure consistent, timely data collection and sharing.** Meaningful and reliable performance measures hinge on collecting timely and accurate data from disparate sources. Then, aggregating, analyzing, and sharing results with stakeholders in a way that enables them to track performance and drive meaningful change that improves outcomes.

4. **Incorporate patient-centered outcomes.** Include outcomes important to patients, such as their quality of life during and after treatment. Focus on functional outcomes, such as range of motion and function pre- and post-surgery, ability to work and take care of their families, and ability to return to normal activities of daily living. Consider using available screening tools such as the Medical Outcomes Study's Short Form (SF) questionnaires SF-36 or SF-12, or other evidenced-based instruments. SF-12 is an abbreviated version (12 items) of the SF-36 Health Survey. The survey is a generic assessment of health-related quality of life from the patient's perspective. As we move toward more patient-centered care, patient-reported information is critical in moving toward better outcomes.

Use of value-based payment models

As the workers' compensation industry continues to emphasize improved quality with lower total cost of risk, organizations are in the early stages of shifting from volume to value. While most payers are still operating in a fee-for-service environment, many have expressed an interest in working toward value-based care models. A recent qualitative research project by WCRI examined stakeholders' readiness for and use of value-based care models in workers' compensation. Additionally, the study considered which payment or organizational model would work best for specific conditions or procedures (e.g. bundled payments for surgery, capitation for chronic pain, center of excellence models for spine disorders). While the research identified different definitions and varying degrees of experience with value-based models, it also identified a *consistent* interest in the approach across stakeholder groups.[15]

The 2016 study examined the extent to which organizations utilize value-based payment models. The results show that only 13 percent of claims organizations have implemented value-based payment strategies (see Table 3). Of the organizations that reported utilizing value-based strategies, higher performers were more likely to utilize bundled payment models.

Table 3 Survey Question: *Has your organization implemented any of the following medical provider value-based payment strategies?* [492 responses]

Answer	count	%
Bundled Payment Model A single negotiated payment for all services for a specified procedure or episode of care / condition such as knee replacements, spine surgeries, and shoulder arthroscopies	32	7%
Capitation Model Providers agree to a set payment per patient for specified medical services	18	4%
Accountable Care Organization (ACO) Model Care delivery model that ties provider reimbursement to improving overall quality, cost and patient satisfaction	15	3%
Patient Centered Medical Home (PCMH) Model Primary care / occupational medicine-driven initiatives to coordinate patients' care across referrals and the healthcare continuum	12	2%
Pay for Performance (P4P) Model Provider financial incentives or disincentives tied to measured performance	10	2%
Shared Savings Model Reward providers that reduce total healthcare spending for a population of patients or specified episodes of care below an expected level	9	2%
Shared Risk Model Provider performance-based incentives to share cost savings and disincentives to share the excess costs with the payer if medical spend exceeds an agreed budget	7	1%
None / Not Applicable	427	87%

Note: Participants were able to select more than one answer for this question
Source: 2016 Workers' Compensation Benchmarking Study

The 2018 study further examined how organizations are leveraging value-based payment models. Although the cost of healthcare has led claims organizations to rethink how care is delivered, the *use* of value-based models remains underutilized in workers' compensation. Three of the industry executive participants report using bundled payment models, however tracking and reporting of quality and outcome measures was inconsistent.

Greatest Impact Opportunities – Key Strategies

Industry Executives highlight the following recommendations / considerations for value-based payment models.

1. **Change success metrics from "volume discounts" to "value."** To move from volume to value, organizations must start internally by fostering organizational alignment around quality and outcomes. This requires changing the longstanding practice of measuring program success based on percentage of savings metrics.

2. **Leverage value-based payment models by applying them to common workers' compensation injuries.** Consider starting with case rates and/or bundled payments. Payers can consider bundled contracts for particular episodes of care, such as knee replacements, spinal surgeries, and shoulder arthroscopies. Bundled payments alone will not improve quality. It's critical that quality and outcome measures, including avoidable risks, are incorporated in the program design.

3. **Utilize existing Accountable Care Organization (ACO) models.** ACO models historically link provider reimbursements to both quality metrics and a reduction of the total cost of care for an assigned population of patients. In workers' compensation, the population of patients is well-defined and could include a payer population of claims, employer group, or risk pool. Payers should consider leveraging existing ACOs, with the ACO becoming the plan's network.

Leveraging Medical Management Programs Ranked Most Critical to Outcomes

Discussed by: Claims Executive Focus Group

Integrating medical management into traditional claims models

The challenge of managing medical severity and disability durations in workers' compensation has been a catalyst for integrating medical management programs and resources within traditional claims models. The strategic use of clinical resources from a claim's outset has become an industry standard – from 24-hour nurse triage models, to embedding nurses within claims teams, to the use of physician advisors.

The 2017 study examined medical management programs considered most critical to claim outcomes. Given the industry's intense focus on medical and disability management, it's no surprise the three programs ranked most critical to claim outcomes are nurse case management, return-to-work services, and nurse / claims triage (see Table 4).

Table 4 Survey Question: *Please rank in the order of impact the medical management programs you believe are most critical to claim outcomes, with 1 having the "greatest impact" and 10 having the "least impact."* [572 responses]

Answer	Overall Rank	Mean
Nurse Case Management	1	3.49
Return-to-Work Services	2	3.90
Nurse / Claims Triage	3	4.17
Pharmacy Benefit Manager / Network	4	5.38
Utilization Review	5	5.73
Physician Case Management	6	5.75
Bill Review	7	5.86
Company Developed / Owned Provider Network	8	6.65
Peer Review	9	6.96
Outsourced / Leased Provider Network	10	7.11

Source: 2017 Workers' Compensation Benchmarking Study

Medical Performance Management

Discussion Topic #3

Prior studies identify nurse case management, return-to-work services, and nurse / claims triage as the top three medical management programs most critical to claim outcomes. How / when are these resources utilized? What are other disruptive ways to deploy these programs? How are organizations measuring outcomes to support ROI / impact?

Key Considerations:

- How are organizations utilizing return-to-work / stay-at-work outcomes to drive the best claim outcomes?
- What data elements are utilized?
- How and what RTW metrics are organizations using for internal claims resources, providers, employers and/or work locations / operations?

During the 2018 study's qualitative research exercise, industry executives examined how organizations are leveraging medical management resources – including nurse case management, return-to-work services, and triage – as well as disruptive ways to deploy these programs.

Impact of nurse resource involvement

Industry executives report utilizing nurse case management along with 24-hour nurse triage as a standard of claims best practices. The 2018 participants agreed, leveraging clinical resources throughout the claim lifecycle has made a significant impact on their outcomes. Two participants, including a large employer and insurance carrier, report using nurses as claims representatives. "Getting buy-in for a significant organizational design change required a well-demonstrated ROI." Both organizations report over 30 percent reduction in overall claims costs and lower litigation rates. The improved outcomes are attributed to a more holistic approach to claims management, decreased handoffs between claims representatives and nurses, as well as a higher level of trust by employees with a nurse managing their claim.

To quantify the impact of nurse involvement in claim outcomes, Liberty Mutual conducted a research study of 42,000 claims normalized for injury, patient, and biopsychosocial factors. The study results identified quicker return-to-work, 26 percent lower overall costs, and 15 percent faster claim resolution when nurses were assigned. The results demonstrate nurses deliver significant benefits when involved in claims. Medical and total claims costs were reduced by double-digit percentages and employees returned to work sooner, contributing to significant cost savings, increased productivity, and reduced total cost of risk.[16] Additionally, a URAC study of 13,648 claims identified a positive association in return-to-work outcomes when nurses are assigned to claims. The results demonstrate timing of the nurse referral / involvement is critical. Over 50 percent of employees return to work within 90 days when their claims are referred to case management within seven days. Alternatively, when cases are referred to case management after 30 days, only 27 percent of employees return to work within 90 days.[17]

A URAC study identified a positive association in return-to-work outcomes when nurses are assigned to claims.

Impact of disruptive medical management programs

During the focus group research, industry executives examined the disruptive medical management resources / tools organizations currently use or are planning to implement in the near term. The focus groups report a collective focus on health and wellness, as well as alternative care delivery models. Given the significant impact of comorbidities on claim outcomes, it's no surprise that organizations are leveraging disruptive solutions to augment traditional medical management programs. Industry executives report the following key differentiators and results:

- **Use of wellness coaching / personal training to improve employee health**. Industry executives identify the need to leverage more holistic solutions to truly impact comorbidities and employee resilience. For instance, a large employer reports offering an exercise program with personal training for three months. If the employee actively participates, they then extend personal training for up to a year. Program results include reduced temporary total disability days, reduced repeat injuries, improved overall health including weight loss, and decreased medication use. The employer also reports greater employee retention through the program. Additionally, two national insurance carriers report partnering with a wellness service provider to take a holistic approach to workers' compensation coverage and to help keep workers safe and healthy, as well as to lower costs. The programs have resulted in decreased temporary total disability, decreased permanent partial disability claims, and improved health outcomes.

One large employer's mission is for employees to be *healthier* post-injury than they were pre-injury.

- **Leverage diverse tools to improve employee and provider communication**. Proactive communication is critical to facilitating timely care and return-to-work. Industry executives report using multiple communication tools (e.g. mobile apps, text messaging, portals) for workers and providers to access claim details and submit documents (e.g. return-to-work notices, treatment requests). Additionally, a large employer reports using mobile video communication tools – like FaceTime – to meet with employees and providers in real-time, as well as approve treatment decisions on the spot.

- **Use of technology to support provider access and speed to care**. The focus groups reports several emerging technology solutions that offer alternative care delivery models, such as remote / app-based physical therapy and health coaching, use of drones, and telehealth. Utilizing alternative delivery models allows organizations to provide care to employees in remote areas, as well as based on their preferences. "Some employees prefer self-directed care and/or online learning, such as health coaching, exercise programs, and behavioral health services," says one industry executive. Offering alternative delivery models gives employees more flexibility and choice, a customer service best practice. Additionally, a large TPA with marine and remote workers reports utilizing telemedicine and drones to deliver care quickly. The results include improved health outcomes and lower overall claims costs.

Self-reporting, a paradigm shift in workers' compensation claims

Another area of growing interest in workers' compensation is self-reporting, which is allowing workers to report their own claims. Considering the common delays in injury reporting with the traditional claims model and the opportunity to connect the worker with the right care immediately, the advantages far outweigh the risks. One large employer from the 2018 focus group exercise currently uses self-reporting. Program outcomes include decreased litigation and improved employee engagement. Perhaps most importantly, the program has not resulted in increased claims frequency as many fear with self-reporting. "We view self-reporting as a component of claims advocacy and employee engagement," says the employer. Another large employer who is implementing self-reporting states, "Self-reporting is a positive disruption to the way we've done things. It's concerning the industry has historically trusted the supervisor over the employee, that shouldn't be." Claims organizations often encounter many unknowns or incomplete claim details from supervisors, which delays claims triage and assignment. By allowing self-reporting, the employee is invested in the claims process from the outset and triage is done on the spot, improving direction of care and reducing frictional loss costs.

From the insurance carrier perspective, it could be a challenge to get employers to buy-in universally to self-reporting. If carrier organizations demonstrate the value to policyholders, as well as put controls in place (e.g. carriers contact the employer as part of the self-reporting process, having supervisor reporting options where language barriers many exist), the industry could see a real paradigm shift in claims reporting.

Goals / Desired Outcomes Identified by Industry Executives for Discussion Topic #3

- Reduce disability durations.
- Improve employee health outcomes.
- Facilitate timely, quality care.
- Identify opportunities to deploy technology to drive medical management resources effectively.
- Reduce litigation / attorney involvement.

Greatest Impact Opportunities – Key Strategies

Industry Executives highlight the following recommendations / considerations for leveraging disruptive medical management programs.

1. **Include 24-hour nurse triage and nurse case management as a core competency of claims best practices.** Organizations should leverage nurse triage and decision support tools, such as predictive / prescriptive analytics, to ensure effective utilization and deployment of clinical resources throughout the claim lifecycle.

2. **Leverage technology tools to improve triage and speed to care.** Consider the use of telemedicine, mobile apps for remote physical therapy, employee assistance programs, and wellness coaching. Leveraging a multipronged approach to healthcare services allows organizations to deliver care based on employee preferences and provide immediate access.

3. **Incorporate wellness tools to improve employee health and resilience.** Consider partnering with wellness service providers and/or health plan resources for disease management, health coaching / personal training, and/or employee assistance programs (EAPs) to better manage comorbidities and improve claim outcomes.

4. **Examine the option of employee self-reporting of claims.** Consider self-reporting as an extension of claims advocacy and to improve employee engagement. As a first step, organizations can consider offering both employee self-reporting as well as employer / manager reporting.

Macroeconomic & Social Factors' Impact on Claim Outcomes

Discussed by: Claims Executive Focus Group

Medical severity and comorbidities on the rise

There are many macroeconomic and social factors contributing to the escalating cost of medical severity; however, key drivers are comorbidities, the aging workforce, the national opioid crisis, medical inflation, and overall increased utilization of medical resources. According to NCCI, the number of workers' compensation claims with a comorbidity condition nearly tripled from 2000 to 2009, outpacing growth rates of the given conditions in the general US population and with twice the medical costs of otherwise comparable claims.[18] The most prevalent comorbidities in workers' compensation claims are obesity, diabetes, hypertension, and mental health conditions. Comorbidities impede a worker's ability to heal and return to work. As a result, claims with comorbidities, on average, experience increased medical and indemnity costs, increased litigation, and longer claims duration.

Obesity in workers' compensation claims – how big is the problem?

Obesity has become a serious health problem in the US, with nearly 40 percent of Americans having the condition. According to the Centers for Disease Control and Prevention (CDC), obesity is a national epidemic that can have serious effects on physical, metabolic, and psychological health.[19] For employers, decreased productivity and increased absenteeism due to obesity is a significant economic burden. Healthcare costs associated with treating obesity-related diseases are estimated at over $200 billion per year and loss in productivity totals more than $500 billion annually.[20]

Additionally, obesity has a significant impact on workers' compensation claims and outcomes. According to the California Workers' Compensation Institute (CWCI), obese workers lost 80 percent more time from work than non-obese workers and incurred significantly higher claim costs. Claims that have an obesity diagnosis are also much more likely to be an indemnity claim – with 81 percent of these workers incurring lost time, triple the rate for non-obese claims.[21]

The 2016 study results identify the greatest obstacles to achieving positive claim outcomes. Survey participants indicate that psychosocial risk factors and comorbidities are the greatest obstacles (see Table 5).

Similarly, the Workers' Compensation Research Institute's (WCRI) *"Predictors of Worker Outcomes"* research indicates that workers with comorbidities have longer disability durations.[22] Further, NCCI's research findings indicate that claims with comorbidities cost twice as much as like-matched claims.[23]

Medical Performance Management

Discussion Topic #4

Medical severity due to macroeconomic and social factors – such as the aging workforce, the opioid epidemic, mental health, obesity, and diabetes – has a significant impact on claims. What resources, strategies, or data are organizations using to identify, predict, or manage these issues?

Key Considerations:

- According to the World Health Organization, mental health and stress are the leading cause of lost work days and a top driver of overall healthcare costs with an economic burden of 3 to 4 percent of gross national product (GNP).
- How do we integrate behavioral health into medical management programs?
- How do we get buy-in from primary providers?
- Are there mental health biases that must be addressed?
- What data resources are organizations using to predict and/or identify comorbidities? How are organizations measuring ROI?

Table 5 Survey Question: *What are the greatest obstacles to achieving desired claim outcomes? Please rank in the order of the greatest impediment, with 1 being the "greatest obstacle" and 10 being the "lower obstacle."* [492 responses]

Answer	Overall Rank	Mean
Psychosocial / co-morbidities	1	4.08
Lack of RTW option / accommodation	2	4.64
Litigation	3	4.79
Employee / employer relationship	4	5.04
Late injury / claim reporting	5	5.20
Proactive / timely communication with stakeholders (i.e. employee, employer, providers)	6	5.57
Legalese statutory requirements / communication	7	5.63
Employee doesn't understand the workers' comp system	8	5.81
Jurisdiction / geographic differences	9	6.74
Access to care	10	7.50

Source: 2016 Workers' Compensation Benchmarking Study

Leveraging data resources to predict and manage comorbidities

With the growing cost and complexity of claims, utilizing tools to identify high-risk cases as early as possible is a clear competitive advantage. To remain competitive, organizations often use tools such as workflow automation and predictive modeling to ensure consistency in execution and to drive desired outcomes. Workers' compensation claims are affected by numerous indicators, including comorbidities, worker demographics, socioeconomic factors, employment status, as well as current and prior injuries. These various factors, coupled with claim and medical transaction data, are the baseline for predictive modeling tools. Predictive and prescriptive technologies have become increasingly important as key decision support tools in the management of workers' compensation claim costs. Using predictive models allows organizations to quickly identify and assess claims with a probability to incur high claim costs, litigation, and other key drivers of claim outcomes.

During the focus group research, industry executives examined what data resources / tools organizations are currently utilizing to identify and manage comorbidities. Participants report leveraging business intelligence and proactive analytics to quickly identify risk factors and determine which claims are likely to result in larger costs. Key initiatives include utilizing predictive modeling to identify claim risk factors, as well as prescriptive analytics to determine the activities / interventions most likely to impact claim outcomes. Two large insurance carriers and an employer report using artificial intelligence to scan records and claim notes for risk factors, including identifying comorbidities early.

Additionally, the focus groups report what could be a significant paradigm shift -- that addressing a psychological component in a claim shouldn't hold a negative stigma. If organizations identify mental health and/or biopsychosocial issues impacting the claim, providing solutions is much more likely to positively impact outcomes. A large employer reports "We don't worry about if a psychological issue is compensable or not. If psychological treatment will get you better, we'll get you better."

Addressing a psychological component in a claim shouldn't hold a negative stigma.

"We don't worry about if a psychological issue is compensable or not. If psychological treatment will get you better, we'll get you better."

Goals / Desired Outcomes Identified by Industry Executives for Discussion Topic #4

- Focus on total worker health and wellness.
- Use early intervention strategies for comorbidities to improve employee health.
- Enhance employee engagement in health and wellness initiatives.
- Decrease claim risk factors through proactive medical management.
- Reduce total cost of risk.

Greatest Impact Opportunities – Key Strategies

Industry Executives highlight the following recommendations / considerations for addressing medical severity and macroeconomic factors that negatively impact claim outcomes.

1. **Leverage data and advanced technology solutions to predict and proactively manage claim risk factors, including comorbidities.** Organizations should leverage predictive analytics throughout the claim lifecycle with actionable intelligence – like prescriptive analytics – to manage multiple, complex claims risk factors. Examine the use of artificial intelligence to mine large data sets, including medical records and claim notes.

2. **Integrate mental health programs into medical management programs.** Consider leveraging EAP programs, cognitive behavioral health, and mindfulness solutions as part of an integrated medical management solution. To raise awareness, educate claims and medical management professionals about mental health conditions and solutions, as well as known and unconscious bias toward mental health issues by claims professionals and employers.

3. **Include total worker health solutions in medical management strategies.** With the significant impact diabetes, obesity, hypertension, and stress have on claim outcomes, organizations should consider including programs like weight loss, nutritional counseling, and smoking cessation as a part of their overall claims management strategy.

Leveraging Claims Advocacy

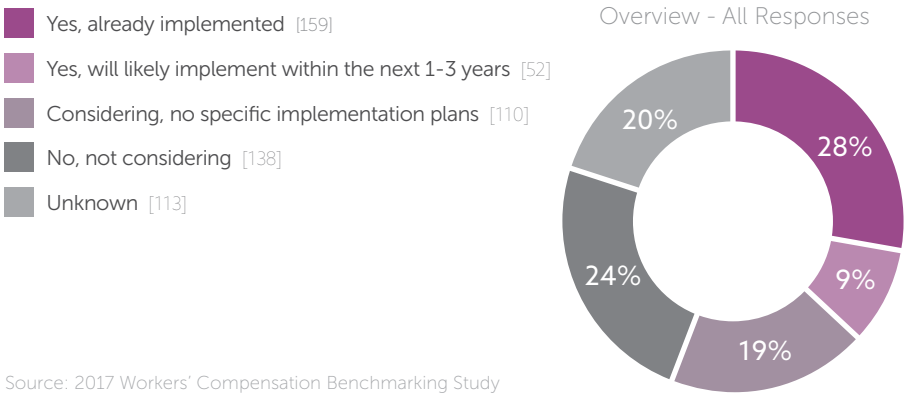
Discussed by: Medical Executive Focus Group

Advocacy as a core value of medical management

The workers' compensation industry has demonstrated increasing interest in advocacy-based claims models, described as an employee-centric, customer service claims model that focuses on employee engagement during the injury recovery process. Such models remove adversarial obstacles, make access to benefits simple, build trust, and hold the organization accountable to metrics that go beyond cost containment.

The 2017 study examined claims advocacy model adoption within claims organizations. The results reveal 28 percent of participants have already implemented an advocacy model (see Figure 2). Additionally, higher performing claims organizations are more likely to have implemented an advocacy-based claims model or are considering implementation.

Figure 2 Survey Question: *Has your organization considered implementing / adopting an advocacy-based claims model?* [572 responses]



Source: 2017 Workers' Compensation Benchmarking Study

During the 2018 study's qualitative research exercise, industry executives examined how organizations are integrating claims advocacy within medical management programs. Participants report integrating claims advocacy initiatives throughout their medical management programs, with a primary focus on employee education / engagement and communication strategies. Most participants report their organizations started by examining when and how they communicate with workers, as well as leveraging different tools such as text messaging, mobile apps, telehealth, and face-to-face visits. Industry executives also report focusing claims advocacy initiatives on accelerating benefits and care delivery by reducing frictional delays, such as unnecessary recorded statements, investigations, and utilization review.

Participants agreed that advocacy is a core value / component of medical management, however there is opportunity to improve organizational awareness and buy-in. Industry executives identified the need to incorporate claims advocacy into medical management program goals, as well as performance metrics to align incentives and desired outcomes.

Medical Performance Management

Discussion Topic #5

The workers' compensation industry is focused on advocacy-based claims models, described as an employee-centric customer service claims model that focuses on employee engagement during the injury recovery process, removes adversarial obstacles, makes access to benefits simple, builds trust, and holds the organization accountable to metrics that go beyond cost containment.

How are organizations integrating medical management into advocacy-based claims models? What initiatives have you implemented, and how are you measuring success?

Key Considerations:

- How is claims advocacy coordinated / integrated into other programs?
- If organizations are considering an advocacy program, where do you start?
- How do we measure the impact on claim outcomes?

Goals / Desired Outcomes Identified by Industry Executives for Discussion Topic #5

- Emphasize workers' compensation as a benefit delivery model.
- Reduce frictional loss costs.
- Improve employee / employer engagement.
- Speed to decision – deliver benefits and the right care faster, with a focus on outcomes that result in more timely resolved claims.
- Advance claims talent development and retention.
- Reduce litigation.

Greatest Impact Opportunities – Key Strategies

Industry Executives highlight the following recommendations / considerations to integrate medical management and advocacy-based claims models.

1. **Leverage a culture of advocacy throughout medical management programs.** Utilize ongoing, consistent communication in program goals and objectives in order to engage claims and medical management stakeholders in claims advocacy. Messaging should focus on advocacy as a continuous, holistic component of the business strategy.

2. **Employ a medical concierge model.** Implement a medical concierge model focused on service delivery with end-to-end coordination of care for workers. The coordination of care begins pre-loss by educating employees about what to do when an injury occurs, and extends to initial triage and coordination of occupational health / specialty provider services, and ends with return-to-work and maximum medical improvement.

3. **Examine traditional claims practices to reduce frictional delays.** Consider eliminating recorded statements and special investigations unit (SIU) probes unless there is a clear need to establish AOE / COE (arising out of employment / course of employment) inquiry. Shorten turnaround time for treatment requests by reducing utilization review requirements, particularly starting with providers that consistently deliver quality care and outcomes.

4. **Develop communication training and education for claims and medical management professionals.** Training should focus on active listening skills, empathy, and how to empower workers to be active participants in their healthcare, recovery, and return-to-work decisions.

5. **Include program metrics focused on claims advocacy core values.** Incorporate Key Performance Indicators (KPIs) focused on speed to decision, such as claim acceptance, delivering healthcare services and benefits faster, employee-centered outcomes / satisfaction, as well as reduced litigation and claim duration.

Conclusion

Since its inception, the Workers' Compensation Benchmarking Study has conducted research for, and with, claims leaders to provide organizations with a means for evaluating strategic aspects of their claim operations alongside industry peers.

From its initial identification of widespread claims challenges / opportunities in **2013** and **2014**, to the **2015** Study's "solutions roadmap" for future advancement, to identifying how and what high performing claims organizations are doing differently than lower performing peers in **2016 and 2017**, the annual Report continually reveals the cumulative intelligence of the workers' compensation claims community.

The **2018** Report is the sixth Workers' Compensation Benchmarking Study directed and published by Rising Medical Solutions. To learn more or to access the study's online Resource Center, visit: www.risingms.com.

Contact

We welcome your reaction to the 2018 Workers' Compensation Benchmarking Study. Please let us know if you find the study useful, have questions about the research, or would like to participate in future studies by contacting Rachel Fikes, VP & Study Program Director, at Rising Medical Solutions: wcbenchmark@risingms.com.

Appendix A

Participant Survey Results

Survey Question:

Give each of the following questions / topics a ranking of 1 to 3 for possible discussion during the focus group exercise.

Discussion Topic	1 lowest priority *(if we had time)*	2 somewhat a priority *(interesting)*	3 highest priority *(most compelling)*	Average Value
Prior studies consistently rank medical management as the most critical core competency to claim outcomes. What are your medical performance management priorities now and in the next two to three years? What have you done that works?	7.5%	20%	72.5%	2.65
The workers' compensation industry talks about quality and outcome-based provider networks, yet many still look for discounts, including the traditional metrics with "savings" below fee schedule methodologies. Are quality and provider outcomes important? If so, how has your organization leveraged quality and outcome-based provider networks? What metrics are you using to measure provider quality and outcomes and/or network results?	5%	40%	55%	2.50
Past study participants rank return-to-work outcomes as the provider quality measure most critical to claim outcomes, however less than 50% report measuring it. How are organizations utilizing return-to-work / stay-at-work outcomes to drive the best claim outcomes? What data elements are utilized?	7.5%	40%	52.5%	2.45
Prior studies identify nurse case management, return-to-work services, and nurse / claims triage as the top three medical management programs most critical to claim outcomes. How / when are these resources utilized? What are other disruptive ways to deploy these programs? How are organizations measuring outcomes to support ROI / impact?	7.5%	45%	47.5%	2.40
Medical severity due to macroeconomic and social factors, such as the aging workforce, the opioid epidemic, mental health, obesity, and diabetes, has a significant impact on claims. What resources, strategies, or data are organizations using to identify, predict, or manage these issues?	10%	42.5%	47.5%	2.38

[cont'd] Give each of the following questions / topics a ranking of 1 to 3 for possible discussion during the focus group exercise.

Discussion Topic	1 lowest priority *(if we had time)*	2 somewhat a priority *(interesting)*	3 highest priority *(most compelling)*	Average Value
How are organizations using provider quality and outcome measures to drive the best claim performance?	7.5%	50%	42.5%	2.35
The workers' compensation industry is focused on advocacy-based claims models, described as an employee-centric customer service claims model that focuses on employee engagement during the injury recovery process, removes adversarial obstacles, makes access to benefits simple, builds trust, and holds the organization accountable to metrics that go beyond cost containment. How are organizations integrating medical management into advocacy-based claims models? What initiatives have you implemented, and how are you measuring success?	12.5%	50%	37.5%	2.25
The impact of drug spending represents a disproportionately high percentage of workers' compensation costs. Increased costs are attributable to drug overutilization, particularly opioids, physician dispensing, compound medications, and specialty drugs. What strategies are organizations using to manage pharmacy overutilization? How are you linking pharmacy management and other medical management programs?	15%	45%	40%	2.25
Data and systems limitations, as well as uncertainty about how to operationalize provider performance measures are major factors limiting their use. What scalable options are organizations using to integrate provider performance measures into their medical management programs?	20%	45%	35%	2.15
According to the World Health Organization, mental health and stress are the leading cause of lost work days and a top driver of overall healthcare costs with an economic burden of 3% to 4% of gross national product (GNP). How do we better integrate behavioral health into workers' compensation medical management programs? How do we get buy-in from primary providers? And how do we break through biases of veteran claims professionals that this is an important issue to address?	32.5%	22.5%	45%	2.12

[cont'd] Give each of the following questions / topics a ranking of 1 to 3 for possible discussion during the focus group exercise.

Discussion Topic	1 lowest priority *(if we had time)*	2 somewhat a priority *(interesting)*	3 highest priority *(most compelling)*	Average Value
The opioid epidemic continues to be a significant concern, particularly combination therapy with benzodiazepines among injured workers. What specific strategies have you implemented to address opioid utilization and dangerous combination therapy?	25%	47.5%	27.5%	2.02
Although the cost of healthcare has led claims organizations to rethink how care is delivered, the use of value-based payment models is still rarely used in workers' compensation. Traditional provider payment strategies are based on a fee-for-service model with discount contracting methodology. Where / how do organizations start leveraging and implementing value-based payment models (e.g. Bundled Payment, Capitation, Accountable Care Organization (ACO), Patient Centered Medical Home (PCMH), Pay for Performance (P4P), and/or Shared Savings / Risk Models)?	32.5%	35%	32.5%	2.00
Provider access, patient convenience, as well as technology advancements have resulted in a greater interest in telehealth / virtual provider visits. How is your organization leveraging telehealth? How do you measure results / success and what are the greatest opportunities?	20%	65%	15%	1.95

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