

ORP Network News

March 24, 2003

1. Contract Status

By now, you should have all received confirmation from our Supply Services department that as a result of the current review which is underway by Nikolaj Consulting and the recent changes relating to the management of the provider services, we will be deferring any amendments to the ORP contract at this time and extending the current contract terms until September 30, 2003. (If you have not received this information please contact Marlies Petura, Supply Services Analyst, at 604-214-6758.) As we move forward with the consultant review, providers from various programs will be contacted to provide feedback regarding the services currently contracted by the WCB, as well as the business processes involved in working with the WCB. We thank you in advance for your participation and candid feedback during this process.

2. ORP Discussion Group Notes - December 12, 2002

In follow up to the Discussion Group that occurred in December, 2002 with ORP providers, following are the notes from that meeting. I would like to take this opportunity to express my thanks again to those that participated and apologize for the delay in the distribution of this summary. (*Information in italics is an addendum to the information that was discussed at the meeting.*)

Participants:

Janet Brydon, WCB; Duane Endo, WCB; Roseanne Mitchell, IMS; Bill MacDonald, Focus On Function; Jon Wilson, Columbia (Vancouver); Andrew Sumner, CBI; Sue Smiley, Work Readiness Program; John Mock, Kelowna General Hospital; Cameron McKay & Tammy Uyeda, Drake Medox; Scott Hutchinson, Columbia (Squamish); Darren Earl, Summit (Nanaimo); Jim Chappell, OT Consulting/Treatment; Kevin Berdusco, Columbia (Langley).

Purpose: to collect feedback from the ORP provider network for consideration during the upcoming contract review. The feedback that has been received from this focus group is for information only and in no way obligates the WCB to fulfill these recommendations in the upcoming contracting process.

OUTCOME MEASURES & PERFORMANCE FEES

1. Maximize function referrals

WCB Perspective:

- One potential concern is that prolonged stays in treatment falsely elevate level of function to a level that can not be sustained.
- Guideline is that these workers should not be in treatment for more than 6 weeks unless they are making substantial gains which will result in a change in their employability.

Discussion Notes:

- Providers would like confirmation regarding whether the 3 month durable outcome for these workers results in a positive outcome in terms of pay-for-performance (p4p). All participants agreed that these workers typically require more attention than the workers with the goal of return to work do.
- If removal of the maximize function clients from the outcome pool results in a reduction in the P4P incentive, then it may be more beneficial to providers to keep them in the pool. Otherwise consideration of an alternative fee schedule for these workers would be recommended (e.g. as in WCP with per day fee for clients > 180 days and no p4p).
- Providers are often asked to keep these workers for longer than 6 weeks. Further CM education is needed regarding length of treatment times.

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Recommendations:

- **Janet to investigate status of maximize function workers at 3 months to determine whether considered successful for measure of 3 month durability. Depending on outcome, alternative fee schedule is recommended if not included in p4p pool.** *(Preliminary data, based on review of one maximize function claim confirms showed that the worker was considered successful for durable return to work outcome. More info will be available shortly.)*
- **Keep in the P4P until further investigation done – keep in financially and in the stats, but identify them separately so that providers are aware of how these referrals are impacting the outcomes.**
- **Contract should make it a requirement that communication be initiated early in the treatment program (i.e. by completion of week 3) with the VR (or the CM in any case) regarding the VR plan for maximize function workers.**
- **If possible develop a separate category in ERCS that would identify these workers and their outcome measures. If not continue with the “Not fit” at assessment and put in body of report that the goal is to maximize function.**

2. Minimum requirement of 50% for RTW w/out limitations at discharge

WCB Perspective:

- Have not been enforcing the 50% expectation. Network average has not achieved the minimum expectation of 50% of discharges fit to RTW without limitations over the last 2 years.

Discussion Notes:

- Would be more value in clarifying the nature of the discharges with limitations (i.e. how many workers are being discharged to a short term GRTW, how many are being discharged with indefinite limitations or modifications). It is the responsibility of the claim owner to establish permanence of the modifications and should not be commented on by the providers.
- The discharge recommendation numbers don't actually define durable RTW numbers.

Recommendation:

- **Remove the 50% minimum requirement for discharge without limitations.**

3. Exclude clients who attend for less than 10 days from outcome measures

WCB Perspective:

- To be consistent with the WCP network, it would be reasonable to eliminate workers who attend treatment for less than 10 days from outcome measures.
- We encourage providers to admit workers who initially demonstrate findings which may not respond well to treatment and provide a short course of treatment to give the worker an opportunity to succeed.

Discussion Notes:

- Many Case Managers request a 2 week trial to determine whether workers will make gains with treatment.
- Concern that potentially successful workers going to a GRTW with limited clinical time (i.e. less than 10 days of treatment) will be eliminated from the outcome measures.
- Clarified that the 10 day period refers to time from completion of assessment to discharge, not “treatment days” in the clinic.

Recommendation:

- **To exclude workers whose assessment to discharge interval is 12 days (2 day assessment + 10 days of treatment) or less from outcome measures.**

4. Introduce minimum response rate for Client Satisfaction Questionnaire

WCB Perspective:

- Concern that providers who do not get a representative sample of questionnaires are being rewarded.
- Consider similar response rate to WCP network (i.e. 60%) as the minimum rate required to earn the client satisfaction p4p incentive.

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- Clients whose length of stay in the program is 12 days or less would not be required to complete the survey and would not contribute to the pool of treated clients for calculation of the incentive.
- WCB made changes to the calculation of the response rate in the summer of 2002, which more accurately reflected the response rate for providers. The degree of completion of the survey no longer impacts the response rate (i.e. the changes should result in increased response rates for providers, without any change in practice on their part).

Discussion Notes:

- Concern raised by providers due to difficulties in achieving the desired response rate due to the GRTW component of the program. Suggested that providers ensure the client gets the survey when they finish the clinical part of their treatment.
- Most providers are achieving greater than 60% response rates and the network average has been greater than 60% for 11 quarters.
- Would clients whose program is interrupted be included? It was suggested that clients who have attended for 12 days of treatment (including assessment) should be given the survey when their program is interrupted.

Recommendations:

- **Implement a required minimum response rate of 60% in order to earn the associated incentive.**
- **Use network average response rate for providers who have had fewer than 10 clients in a quarter.**

5. Eliminate performance incentive fees for Client Satisfaction rate < 8.0

WCB Perspective:

- Intent is to bring consistency between contracts (i.e. ORP and WCP) and to reward outcomes which exceed network averages, rather than those at or below average.

Discussion Notes:

- More clients now have behavioural/complex problems which may skew the averages towards a lower rate.
- The cut-off level for ORP should be lower than the WCP network due to the complexity of the clients. It was suggested that 7.5 be the minimum to achieve incentive.
- Look at the network average and start from there -- With min. of 10 clients. Use network average satisfaction rate for providers who have had fewer than 10 clients in a quarter.
- It was suggested that if the information on the Client Satisfaction Questionnaire is valuable to the WCB then the incentive related to it should be increased.
- It was also suggested that the calculation of the p4p incentive be done semi-annually or annually instead of quarterly to ensure that providers with fewer referrals had a reasonable sample size.
- Consider increasing the flat fee and the bonus/incentive.

Recommendations:

- **Use network average satisfaction rating for providers who have had fewer than 10 clients in a quarter.**
- **Agreement to raise the bar for earning of the satisfaction incentive.**

Note: Network average over the last 15 quarters = 8.08.

REPORTING

6. Interim reporting due date

Discussion Notes:

- More information is available after the 3rd week, particularly for clients participating in 10 weeks of treatment.
- Average treatment length is just over 7 weeks, so 3 weeks is closer to the mid-point.

Recommendation:

- **Change Intermediate Report due date to the end of the 3rd week of treatment instead of day 10.**

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7. Report fee for the discharge report instead of the intake report

WCB Perspective:

- Timely submission of the discharge report is more critical for claims decision making.

Recommendation:

- Report fee to be paid for Discharge Summary Report if submitted within 3 business days of discharge date.

PROGRAM STANDARDS

8. Caseload numbers

WCB Perspective:

- Feedback received from unsatisfied clients regarding lack of attention and overcrowding.
- Consistent feedback from providers that the complexity of clients is increasing.

Discussion Notes:

- Providers asked for clarification regarding the source of concerns (i.e. does it depend on adequate space provided or clinician availability?).
- If the problem is based on lack of supervision, then that will be a concern regardless of the number of clients on the caseload. This is a problem that should be addressed with the individual clinic.
- Maintain the current caseload numbers, but clinics should be responsible for ensuring that they are able to supervise the workload that they have effectively. This will depend on the expertise and experience of the staff members involved.
- Decreasing caseloads could have substantial financial impact on some clinics.
- When we are discussing caseload numbers, are we considering those on GRTW as they require minimal intervention? The argument is that at least one team member is still monitoring those clients.

Recommendation:

- Increase caseload to 20, which would include a maximum of 15 in clinic and an additional 5 on GRTW.

9. Modified treatment requests

WCB Perspective:

- Some providers are using requests consistently and typically most are approved.
- Some providers are modifying treatment without submitting requests.
- Initially implemented to ensure that rationale for treatment modifications was reasonable.

Recommendation:

- Discontinue need for Modified Treatment Authorizations from ORP Program Manager or Quality Assurance Supervisor.
- Case Manager approval still required.

10. Other Standards Manual clarifications

- Method of reporting for consulting clinicians: prefer first person, no handwritten reports. Clarification regarding reporting requirements will be provided in revised Standards Manual.
- Expectations for JSV reports: Clarification regarding reporting requirements will be provided in revised Standards Manual.
- GRTW monitoring: minimal expectation of weekly phone contact to be included in revised Standards Manual.
- Authorization process for interpreters should be considered for the Standards Manual.

OTHER ISSUES

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11. Fees

WCB Perspective:

- Increase planned, amount to be determined.
- An increase in both the flat fee and the incentive payments is not anticipated.

Discussion Notes:

- Physician costs have increased. Current fee for physician assessment does not cover cost. Initially, the physician assessment fee (which was billable for a maximum of 25% of the clients) was included as an extra fee, however the physician services are intended to be part of the flat program fee. The 25% maximum was not enforceable.
- Providers requested that a fee be put in place for assessment cancellations. A fee of \$50 was suggested.
- The contract should outline timelines for payment of P4P incentives.

Recommendations:

- **A flat fee of \$4000 was suggested. Participants indicated that they would like to review further and provide further input.**
- **Duane and Janet will review how other board-sponsored programs manage cancellations. To the best of our knowledge, no other treatment programs pay cancellation fees.**

I have confirmed that no other board sponsored treatment programs pay a cancellation fee. A "referral fee" is paid for assessment services (i.e. FCE's, PFI Evaluations) which forms part of the overall service fee. This fee is paid for all referrals whether the assessment is completed or not. It is only payable once and is payable if the worker or WCB cancels the assessment.

12. Communication with claims staff

Providers' perspective:

- There should be a standard where it is required that claims staff participates in regular communication with providers to provide an avenue for dialogue.

WCB perspective:

- The Standards Manual governs the behaviour of the providers and not the Board Officers; a change to the Standards will not result in the desired change. This needs to be discussed with claims staff for their input.

13. CARF accreditation

Providers' perspective:

- What is WCB's position on accreditation?
- Accreditation is time consuming and expensive.
- Hospital accreditation would be an equivalent to CARF.
- There are benefits to participating in the CARF process, but the value declines with repeat accreditations.
- The process promotes self-evaluation of service practices.
- It is a huge expense for small providers.

Recommendation:

- **WCB to consider whether CARF accreditation is a mandatory requirement for contract or value added benefit.**

Later feedback from participant is to consider having a fee schedule that pays more to providers who have successfully achieved accreditation.

3. INFORMATION BULLETINS

The following Information Bulletins relevant to the ORP network have been distributed since the last Network News (December 2002):

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- 2003-03 ERCS Exporting and Data Encryption
- 2003-04 Encryption of Client Data
- 2003-08 Provider Services Management Changes
- 2003-10 Services Management and Contacts Update
- 2003 -11 Nikolaj Consulting Inc.

If you have not received any of these bulletins, please contact Duane Endo, Quality Assurance Supervisor at 604-231-8895 or 1-888-967-5377 (local 8895).

If you have any questions or comments please feel free to contact me at 604-231-8841 or 1-888-967-5377 (local 8841).

Janet Brydon
Program Manager,
Health Care Provider Services