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## **Task 6**

### **Report on the Health Care Provider, Office Staff and Employer Focus Groups**

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## **Report on the Health Care Provider, Office Staff and Employer Focus Groups**

Over the past seven months the UW research team conducted a series of focus groups with COHE providers, provider office staff and employers. The first focus group was conducted in November 2007 with Renton COHE providers, followed shortly by the second focus group held with office staff. During February 2008, the UW research team conducted focus groups with Spokane providers and office staff. The final focus group, held in June 2008, was conducted in Yakima with employers from eastern Washington. The purpose of the focus groups was to gather qualitative information regarding the design and operation of the COHEs from the perspectives of three groups. We were particularly interested in learning what focus group participants valued with regard to the COHE design features and what factors they perceived as challenges or impediments to progress.

The focus groups were guided by a set of broad questions concerning COHE incentives, design features, ability to deliver care to injured workers, and online use of the Department of Labor and Industries (DLI) Claim and Account Center (CAC). Each focus group lasted approximately one hour and involved 8 to 12 participants. Suggestions for attendees were solicited from the COHE staff with direction to include those providers who were enthusiastic adopters of COHE best practices and those who struggled with the best practices. We also attempted to include participants from a variety of practice settings: orthopedic and occupational medicine specialists, family practice, and chiropractic offices as well as emergency rooms and urgent care clinics. For the staff focus groups, the key staff member dealing with COHE practices in the offices of the providers who participated in the provider group were invited. A summary of information gathered through the focus groups and the key points made by participants are provided below.

## **Provider Focus Groups**

### **Incentives**

Provider opinions regarding the importance of financial incentives were divided. Renton COHE providers thought enhanced billings were not of major importance. Some of the providers noted they were on salary and thus did not directly capture enhanced billings. It was also noted the amount of extra revenue that could be earned via the COHE financial incentives was small in comparison to what is offered through the Ortho-Neuro project. On the other hand, some participants mentioned that having enhanced revenue generated from COHE billings had allowed the office or clinic to hire an additional staff person to assist with care coordination.

In contrast, Spokane COHE providers felt the financial incentives were important, despite the modest amount of additional revenue available. Providers stated that the enhanced billings provided incentives to pay more attention to paperwork, especially with regard to submission of the report of accident (ROA). As one provider noted, “When I see a ROA on the desk, I see money flying out the door if I don’t pick it up and process it.”

More important than financial incentives, however, were the non-financial incentives provided through the COHE. Providers at both pilot sites were universal in their enthusiastic, positive attitude regarding the role of the health services coordinators (HSCs). This sentiment reflected the strongly-held perception that the HSCs served as “problem solvers,” helping to resolve a host of care coordination and claim management problems and issues.

Providers at both pilot sites also felt the development of the activity prescription form (APF) was a key attribute of the COHE. The fact that the APF replaced other forms, thus reducing paperwork, was viewed by providers as a welcome change and major step forward in improving administrative efficiency.

### **Online Use of DLI's Claim and Account Center and Use of Athena**

COHE providers at both pilot sites were queried about whether they used the DLI Claim and Account Center (CAC), and Spokane COHE providers were asked whether they used the Athena system. Providers in the focus groups indicated they did not use these systems. But as discussed below, office staff and employers reported they did use the CAC and found it very helpful for obtaining information regarding claim status. Spokane providers in their focus group reported not using Athena, although some of their staff use Athena.

### **Provider Perceptions Regarding Positive Features of COHE**

Providers at both pilot sites indicated the most positive features of the COHE were (not in rank order):

- use of HSCs to help with care coordination and claim management
- reduction in paperwork associated with the development of the APF
- having injured workers who were referred to a specialist seen in a timely fashion.

Providers were uniformly enthusiastic about the reduction in paperwork and about the important role played by HSCs in care coordination. It is clear from the provider perspective that HSCs play a critical role in the COHE operation.

Providers in the focus group noted that HSCs take a proactive approach to coordinating care, communicating with employers and facilitating claim management. Focus-group providers also noted that HSCs tended to be viewed by injured workers as “neutral parties” in care management processes. Accordingly, in cases where job accommodations or light duty were being considered to facilitate early return to work, a worker may be more likely to accept that option if he or she felt the HSC was acting as a neutral party. In general, it was felt that HSCs are more proactive in coordinating care than third-party administrators (TPAs), which tend to focus more on claim management processes.

Providers at the Renton pilot site offered an interesting insight regarding the COHE and its effect on worker expectations related to time loss. Prior to COHE, injured workers often expected to be out on time loss at least for some amount of time. But this expectation changed as a result of the COHE, in part, because injured workers observed COHE providers calling the employer during the office visit to discuss options for return to work.

### **Changes that Could Be Made to Improve COHE Operations**

Provider focus group participants were queried about what COHE design features might be changed to improve the operation and performance of the COHE. This question did not elicit strong responses because providers showed a high level of satisfaction with the COHE. Some points were noted, however. A few providers indicated that having the COHE forms available in electronic medical record (EMR) format would be helpful. Providers in the Renton focus group mentioned it would be helpful to have more frequent contact (in person or via mail) with the HSCs and to be informed when a change in HSC staffing occurs. Providers in the Spokane focus group felt that having self-insured employers participate in COHE would be helpful. Providers from the Spokane focus group voiced strong objection to the heavy paperwork burden imposed by some self-insured employers and felt this burden could possibly be reduced if self-insured employers participated in the COHE and accepted the use of the APF and other forms.

### **Change in Ability to Work with Employers**

Providers indicated the COHE had improved their ability to work with employers. Communication with employers was better because of HSCs. Providers felt the APF had improved their ability to document important information and to communicate this information to employers.

### **Summary of Provider Comments**

Providers showed significant enthusiasm for the COHE and its role in improving the process of care. The two most important factors leading to the strong level of support for the COHE appeared to be the introduction of the APF and the use of HSCs. While some

comments were offered regarding what the DLI might have done differently in designing the COHE, these comments were not offered as criticisms. Focus group participants felt the tools provided through the COHE were “on target” and effective in promoting improved quality. Finally, Spokane focus-group providers noted that COHE injured workers benefited from timelier referral to specialists. Prior to COHE, it was not uncommon for an injured worker referred to a specialist to experience delays of several weeks. Now COHE injured workers referred to specialists are often seen within ten days.

## **Office Staff Focus Groups**

### **Incentives**

Although focus group participants who were clinic office staff acknowledged the value of financial incentives, they felt non-financial incentives were more important. In particular, they felt the streamlining of forms, the development of the APF, and the increased timeliness of form submission were important benefits of the COHE. One participant summed their feelings up as follows, “Everything works better and more quickly under COHE.”

Office staff participants echoed the views of the providers regarding the central importance of the HSCs in care coordination, communication and claim management. They also noted the benefits of the APF and the fact that the injured worker had to be seen by a provider in order to get continued time loss certified via the APF. Previously, this was not required when the time loss notification (TLN) form was used. Injured workers often dropped that form off or mailed it into the health care provider’s office where it might get misplaced. With the use of the APF for authorization of time loss, the injured worker has to see the provider which has decreased office “no-show” rates in both COHEs. The lack of provider-injured worker contact was felt to be an impediment to return to work, which, in part, was overcome by the introduction of the APF. An additional benefit of the APF expressed by one staff member was that the APF identifies the restrictions so well that there are fewer calls back from employers with questions.

### **Online Use of DLI's Claim and Account Center and Use of Athena**

The experiences of office staff in using the DLI Claim and Account Center (CAC) differed. The Spokane pilot office staff indicated they used the CAC to a limited degree, and then did not find it very useful. In contrast, the Renton pilot office staff indicated they used the CAC frequently and found it very helpful. The reason for the different experiences of office staff is unclear. Spokane office staff were also queried about their use of Athena. In general, office staff indicated they used Athena infrequently. One staff person voiced the strong opinion there was need for better training in the use of Athena. A contrasting view, however, was offered by an office staff person working in an occupational medicine clinic setting. She indicated she used Athena daily for data entry and for checking the dashboard, and found it to be very useful for these purposes.

### **Office Staff Perceptions Regarding Positive Features of COHE**

Like providers, office staff participants voiced strong support for the COHE. They felt the COHE had improved the flow of information and communication between the provider and the employer. Injured workers benefited from having claim procedures and care processes (e.g., claim authorization and specialty referrals) operate more effectively. Renton office staff singled out the importance of the APF in improving care management and, in general, having paperwork flow operate more efficiently under COHE.

### **Changes that Could Be Made to Improve COHE Operations**

The question regarding the design and operational features of the COHE that might be changed to enhance performance elicited diverse responses. The Spokane participants tended to highlight issues regarding Athena, e.g., the need for more detail on the Athena dashboard and the potential value of notifying employers about Athena. They also mentioned the desire for further reductions in paperwork. Renton participants indicated it may have been useful to have dedicated claims managers for the COHEs and to have advertised the COHE to employers at the time of start-up to enhance support for the pilot.

### **Change in Ability to Work with Employers**

Office staff at both pilots indicated the COHE had improved their ability to work with employers. Provider and office staff communication with employers was better; office staff participants felt employers now had confidence that “things were getting handled more efficiently.” Office staff focus-group participants reinforced the view held by provider participants that HSCs played a central role in improving provider-employer communication.

### **Summary of Office Staff Comments**

Like providers, office staff showed significant enthusiasm for the COHE and its role in improving the quality of care. They felt the improvement in flow of information brought about by the introduction of the APF and timely submission of the ROA, along with the critical role played by the HSCs, were important factors leading to quality improvement. Office staff also commented on the trend toward adoption of the electronic medical record (EMR) and the need to integrate COHE paperwork in the EMR.

### **Employer Focus Group**

Employer focus group participants were asked an abbreviated set of questions pertaining to the usefulness of information they received through the COHE, their views about the COHE and its positive features, changes in their ability to work with providers and changes they would like to see made to improve COHE performance.

### **Information Received through COHE and Use of Athena**

Employer focus group participants stated they valued having the COHE staff and the HSCs communicate with providers. They felt this communication improved care coordination and claim management. They expressed some indifference regarding the person initiating contact, health care provider or office staff, as long as that person provided the pertinent information in a timely fashion. Employer participants indicated they felt the COHE had improved claim management, hence claims were getting

approved more quickly and treatment for the injured worker was proceeding on a timelier basis.

Employer participants did not use Athena to any significant degree, though some participants found the claim notification process through Athena helpful. The majority of employer participants stated a preference for using the DLI CAC. From the employer perspective, Athena duplicated the CAC. In general, employers indicated the information they received through COHE was very useful in helping them promote improved return to work among injured workers.

### **Views about the COHE and Its Positive Features**

Employer participants expressed very positive views regarding the COHE. Like participants in the other two focus groups, employers had praise for the APF as a tool to better organize care management and information flow and for the important role played by HSCs. Selected employer participants stated the APF helped them in their internal discussions regarding the availability of light duty or job accommodation to promote return to work. Employers also indicated that under COHE health care providers were more willing and better able to communicate with them about injured workers and what was needed to promote return to work. Employers attributed this improved communication ability to the incentives provided through the COHE. Of interest, one participant indicated she felt the COHE had been successful in recruiting a broad spectrum of health care providers, including health care providers who were less knowledgeable about workers' compensation and the delivery of occupational medicine. This participant felt this was a very positive outcome of the COHE, and other employer participants agreed.

### **Changes in the Ability of Employers to Work with Providers**

Focus-group employer participants felt the COHE had improved their ability to work with providers. Under COHE, communication with providers had become more standardized (via the APF). At the same time, employers perceived providers were more willing to give them information about the injured worker and his or her needs as they

related to recovery and return to work. One employer stated they felt the COHE had “taken some of the scariness” away for health care providers who were more reluctant to communicate with employers.

### **Changes that Could Be Made to Improve COHE Performance**

The question about changes that could be made to enhance COHE performance elicited limited information. One employer participant stated they would like to see the COHE expand into the Tri-Cities. Another indicated they would like to see some technical changes in Athena to improve its “user friendliness.” Another employer indicated he would like the APF modified so that if an injury were minor and required no further treatment that information could be noted on the initial APF. This may help to speed up claim closure.

Perhaps the most interesting suggestion for change was the idea of the COHE providing information to employers and injured workers on topics germane to injury recovery and occupational health. It was suggested this could be done via Athena or via the DLI website. Employer participants felt there was a great deal of ignorance within the employer community and among injured workers regarding injury prevention and what to do to promote recovery and return to work.

### **Summary of Employer Comments**

Employers were strongly supportive of the COHE and the changes it has brought about in provider-employer communication and in care coordination. They felt the COHE had improved the knowledge base of health care providers and, in general, enhanced the quality of medical care provided to injured workers in eastern Washington.

### **Conclusion**

Focus group participants were very positive about COHE and its ability to promote best practices and improve quality. Participants viewed HSCs and APF as especially important in improving care processes. Focus group participants seemed to feel COHE

had provided a “critical support system” for promoting best practices and improving quality.