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Ethical Considerations of an Outcome Based Vocational Rehabilitation Fee Schedule

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Abstract. The primary purpose of this mixed-methods study was to assess vocational rehabilitation (VR) providers' opinions related to how a vocational rehabilitation outcome based payment schedule (VR-OBFS) may affect VR services for injured workers. One hundred rehabilitation counselors currently working in the state of Ohio completed a survey comprised of Likert-type and open-ended questions. The survey instrument for this study was created by the researchers in collaboration with a Delphi Panel consisting of fifteen established VR providers from Ohio who have worked in VR for an average of 25 years (range of 7-34 years). Panel members collaborated during three rounds of review and feedback. Survey questions asked VR professionals to consider how a VR-OBFS may affect VR services for injured workers including factors such as duration and quality of services. Participants were also asked to describe the ethical challenges they may foresee as a result of the implementation of the VR-OBFS. The findings of the current study highlight concerns related to how rural areas will be affected, the financial consequences, complex case selection, and the ethical dimensions of the policy. Ultimately, VR professionals expressed fears that the best interests of the IW will no longer be the sole focus of treatment and, as a result, a VR-OBFS would sanction a direct contradiction to the CRCC Code of Ethics.

Keywords: rehabilitation counseling, VR, ethics, outcome based payment fee schedules

The Ohio Bureau of Workers Compensation (BWC) has recently proposed moving from a fee-for-service to a vocational rehabilitation outcome based fee schedule (VR-OBFS) effective January 1, 2015. In January 2014, in their presentation "VR Provider Fee Schedule Recommendations for 2014," the Ohio BWC indicated that principle guiding the fee schedule change is, "To ensure access to high-quality vocational services by establishing an appropriate benefit plan and terms of service with a competitive fee schedule which, in turn, enhances BWC's vocational provider network" (p.2). There is a growing concern among rehabilitation counselors that a "competitive" (outcome based) fee schedule may have deleterious effects on the ability of rehabilitation counselors to provide competent services in line with the ethical standards that VR professionals are obligated to uphold, and, most importantly, that the fee schedule change may result in risks to the wellbeing and best interests of injured workers (IWs). A multitude of ethical considerations should be taken into account before any policy changes are made. The purpose of the current article is to assess the opinions and ethical concerns of VR professionals currently working in the state of Ohio.

The proposed research questions for this study are:

1. How would the proposed VR-OBFS affect vocational rehabiliation services for IWs?
2. Would a VR-OBFS affect the duration of vocational rehabilitation services offered to IWs?
3. How do rehabilitation counselors describe the ethical considerations that could potentially occur as a result of the implementation of a VR-OBFS?

Literature Review

The Commission on Rehabilitation Counselor Certification (CRCC) is committed to advocating for both its Certified Rehabilitation Counselors (CRCs) and the profession of rehabilitation counseling (2014). The mandatory standards delineated in the *CRCC Code of Professional Ethics for Rehabilitation Counselors*

(2010) are intended to assure the community that the rehabilitation counseling profession accepts its responsibility to provide caring, competent and ethical services to individuals with disabilities (CRCC, 2010). The Preamble states, "Regardless of the specific tasks, work settings, or technology used, rehabilitation counselors demonstrate adherence to ethical standards and ensure the standards are vigorously enforced" (CRCC, 2010, p. 1).

A salient contextual factor that is imperative to consider in the domain of ethics in rehabilitation counseling settings is policy and legislative implementation as it relates to the provision of VR services. As a result of a VR-OBFS, the scope of services provided to clients may be limited in that rehabilitation counselors with higher return-to-work (RTW) rates may feel pressured to focus their energy on obtaining clients that may take less time to return to the workforce as compared to more complicated cases (e.g., traumatic brain injury) that will require more time before a return to work is possible. This dynamic could potentially create a VR environment driven by outcomes leaving clients with more acute medical/mental health conditions paired with rehabilitation counselors that may have lower RTW rates and, as such, less clinical experience.

Practices in rehabilitation counseling are influenced by numerous factors, including types of clients served, types of cases, laws and regulations covering the VR services, approaches to counseling, cultural diversity of clients, and ethics. In the area of ethics, additional factors can impact the services provided and the relationships between rehabilitation counselors and clients. Examples include consideration for multicultural competence, professionalism, confidentiality, appropriate boundaries, and development of assessments (Welfel, 2010). The newly published American Counseling Association Code of Ethics (2014) focuses extensively on developing the following values within the profession: (a) "autonomy;" (b) "nonmaleficence;" (c) "beneficence;" (d) "justice;" (e) "fidelity;" and (f) "veracity" (p. 3). The Commission on Certification for Rehabilitation Counseling (2010) similarly advocates for the profession and its clients, including the avoidance of harm, providing for the welfare of the clients, and advocating for the rights of clients (Barros-Bailey, Carlisle, & Blackwell, 2010). Although there are specific guidelines provided by professional associations, ethical boundaries are highly complex when considering the context of each situation. Ethical decision-making is not simple in that there are multiple interactions between counselor, client, and other professionals. Despite the Code of Ethics serving as a baseline, counselors also face challenges in the types of modalities (e.g., individual, family, group); professional identity (e.g., community, clinical mental health, rehabilitation, school); and work settings (e.g., managed care, private sector, public sector, non-profit sector). The confluence of these factors creates complex situations that may hinder counselors' abilities to operate effectively in providing services.

The Ohio BWC has proposed redefining the VR fee schedule affective January 1, 2015. This policy change resembles the (1998) study of Vaughn, Taylor, and Wright. Specifically, their study was formed in response to changing policies regarding managed health care and the continuous growth of both the private sector and the rehabilitation counseling profession. Due to this extensive change, Vaughn et al. (1998) hypothesized that ethical challenges would persist and become more complex. This study focused on how managed care professionals are challenged ethically as a result of pressures from the policies of overarching organizations. The results of their study demonstrated that rehabilitation counselors faced a variety of ethical challenges, which created conflicts among the ethical values of rehabilitation counselors (e.g., beneficence, justice). Similarly, rehabilitation counselors may be affected from the pressures of policy changes within the BWC. This pressure adds to the complexity of ethical issues that are inherent to private-for-profit rehabilitation counseling.

Effects on Client Services

When the focus of VR service provision relies heavily on outcomes, counseling relationships and services can potentially become less effective. McCarthy and Leierer (2001) noted that the decline of VR services has occurred primarily due to the discrepancy between viewpoints of providers and clients on needs and successful outcomes. In their literature review, they noted that clients observed that they were receiving rehabilitation services largely different than what was expected (McCarthy & Leierer, 2001).

Wagner, Wessel, and Harder (2011) also highlighted the importance of the "working alliance" between professionals and clients (p. 46). They noted that a major concern of clients was their service providers' investment in their needs. Clients often held the "working alliance" in high regard with the particular need for feeling respected, professionalism on the part of the counselor, and advocacy. Using the perspective of rehabilitation counselors, Lane, Shaw, Young, and Bourgeois (2012) explained that pressures from the workplace environment hindered the ability to develop stronger counseling relationships that would facilitate rehabilitation for clients.

Prior research that illuminates the perspectives of clients indicates that the most ideal service providers in rehabilitation counseling were often characterized as "client advocates" (McCarthy & Leierer, 2001; Wagner et al., 2011). The major theme in this characterization is the vital importance of the clients' perceptions of the working alliance (i.e., does the client feel re-

spected and understood by their service providers?). McCarthy and Leierer (2001) noted that clients often described ideal counselors, using the words "empathy" or "understand" (p. 15). A pertinent finding in their study is how clients regard behaviors and personal characteristics as more important than the training and credentials of their providers.

Although the findings from McCarthy and Leierer (2001) explained that personal characteristics and behaviors were significant, participants in this study noted that the minimum qualifications of counselors should include appropriate credentials and training. However, the theme of personal characteristics and professional behaviors were more consistent and significant to the clients in the study, as those characteristics facilitated perceptions of ideal counselors. A notable conclusion from both studies (McCarthy & Leierer, 2001; Wagner et al., 2011) is the significant theme of advocacy. Clients reported that providers who communicated their intention and dedication to advocating for the needs of their clients were more favorably perceived.

Ethical Conflicts

Altering the fee schedule for VR professionals may potentially trigger several ethical conflicts. Utilizing the findings from other researchers (Hagglund & Frank, 1996; McCarthy & Leierer, 2001; Wagner et al, 2011), counselors held under a more outcome-based fee schedule may operate in a manner that is different from the perceptions of ideal counselors. Operating under an outcome-based fee schedule could pressure rehabilitation counselors into moving forward with service plans too rapidly or before the client is medically stable (i.e., reaching maximal medical improvement), and, as a result, the trusting alliance between counselor and client may be impeded (Hagglund & Frank, 1996; Lane et al., 2012). Clients may then feel that their rehabilitation plan or VR services are not properly meeting their needs. While rehabilitation counselors may not be appropriately meeting clients' needs, the additional situation to consider is that rehabilitation counselors would have a higher potential to make mistakes due to an increased pressure to ensure outcomes are met within a specific time frame. The increased potential to make mistakes affects proper case note writing, case management, and consultation with other professionals (e.g., physicians, physical therapists, psychologists), which are vital to meet high standards in rehabilitation counseling practices (Ethridge, Rodgers, & Fabian, 2007; Zanskas & Leahy, 2007).

Informed consent. The CRCC holds the rehabilitation counseling profession to a high standard of best practices. Part of their high standards in the ethical code includes informed consent (Blackwell & Patterson, 2003). Considering the bounds of informed consent, proposed changes in the VR fee schedule could increase risk and complexity for rehabilitation counselors to properly communicate components of informed consent. Those risks primarily include explaining the fee schedule to clients as part of the informed consent process. Blackwell and Patterson (2003) argued that informed consent needs to require more specific guidelines in communicating fees to clients. These guidelines would help to ensure that clients are knowledgeable about their services and their ability to obtain affordable services. Since informed consent is a primary concern, changes in the VR fee schedule will force rehabilitation counselors to revise how they would communicate the outcome based fee structure to clients.

Transparent communication about services, competence, and fees are requirements of informed consent. A standard within the field of counseling is that practitioners are appropriately communicating the qualifications and skills necessary to work with a particular population (Welfel, 2010). When those qualifications do not match the needs of the client, rehabilitation counselors are encouraged to openly discuss their competencies with their supervisors and provide appropriate referrals. The primary challenge with the Ohio BWC proposed changes in the VR fee schedule is that the services may be primarily based on outcomes. When services are based on outcomes, more qualified rehabilitation counselors with higher return-to-work (RTW) rates could potentially favor cases that require a lesser complexity of disability. This course of action would be an effort to meet the outcome-based pressures implemented by the fee schedule change. Rehabilitation counselors with lower return-to-work (RTW) rates may not have enough experience to serve the higher complexity of disability in more acute cases. Rehabilitation counselors may be pressured to take on clients in order to manage their own counseling practice. As a result, the welfare of clients may inadvertently become a secondary priority.

The Current Study

The purpose for the current research study arose out of the concerns regarding the Ohio BWC proposed change in the VR fee schedule and the paucity of research regarding rehabilitation service provision and the ethical conflicts resulting from a VR-OBFS. Many of those concerns were based on how the proposed VR fee schedule change could potentially affect rehabilitation counselors and their clients. With a fee schedule change, the possibilities of changes regarding the practices of VR counselors are likely. The recent change would also elicit VR practices that are based primarily on outcomes. When practices are focused on outcomes, the margin for providing a respectable, ef-

fective working alliance with clients could potentially be diminished.

Method

A descriptive, convergent parallel mixed-methods research design was implemented for the current study. This approach utilized quantitative, qualitative, and ex post facto approaches to develop the model that would drive the research questions. In this design, the researchers aimed to collect both the quantitative and qualitative data from participants simultaneously. Both sets of data (quantitative and qualitative) were analyzed separately for possible themes and findings. Those themes were later merged together to form the findings within this study. The rationale for this research design was also derived similarly from the design of the study conducted by Szymanski, Leahy, and Linkowski (1993).

Delphi Method

The Delphi method was originally formulated to address a historical issue at the Rand Corporation in the 1950s (Hsu & Sandford, 2007). When the method was developed, the goal was to form a group consensus with the intention to predict both the present findings and future trends. By discussing future trends, researchers could seek findings that would develop innovation by hypothesizing the outcomes of specific changes in practice. This type of future trend prediction would be able to discuss the outcomes of policy changes, legislation, and practices. In the context of this study, the application of the Delphi method was salient to predicting the possible changes from the revision of the VR fee schedule in Ohio.

The first step in implementing this study was to utilize processes that embodied the Delphi method of research. The Delphi method utilizes consultation from a panel of experts in order to actively participate in the process of developing the instruments to be disseminated among participants and research questions for investigation (Vazquez-Ramos, Leahy, & Hernandez, 2007). The intention of using this method is to address a particularly complicated issue, which uses the group opinion of experts in a particular field. The intention behind operating within a group consensus is to prevent biased perspectives from the researchers and influencing views from the participants within the development of the study. During the process, the opinions held by the panel of experts are treated to several rounds of review and feedback, which would refine the consensus of the opinions (Hsu & Sandford, 2007; Vazquez-Ramos, Leahy, & Hernandez, 2007). Forming these several consensus opinions would allow for further exploration of alternatives to form resolutions for the specific issue addressed (Hsu & Sandford, 2007).

Participants

The sample for this study consisted of 100 participants. All participants were current VR practitioners working in the state of Ohio with workers' compensation clients. According to the Ohio Bureau of Workers' Compensation (2014), there are approximately 200 VR providers in Ohio. As such, our survey obtained approximately 50% of the total number VR providers in the state.

Participants were recruited via the secure email invitation program provided by Survey Gizmo, one of the country's leading professional, web-based survey providers. A list of email addresses of 127 vocational rehabiliation providers in Ohio was provided by the International Association of Rehabilitation Professionals (IARP). The sample included 100 out of 127 IARP members who provide VR services in Ohio. Thus, the response rate was 78.74% after sending three email requests to participate in the survey. Prior to sending the invitations and recruiting the participants, the researchers obtained Internal Review Board (IRB) approval from The George Washington University Office of Human Research. Participation in the study consisted of providing answers to the online questionnaire.

Of the recruited professionals, 126 participants started the survey; however, only 100 completed the survey. Responses to questions were optional, thus resulting in some questions with less than 100 responses. The final sample of participants included 71 females (71.7%), 28 males (28.3%) and one participant did not report a gender. Mean age for the sample was 51.62 years, ranging from 29 to 72 years of age. The majority of participants reported their ethnicity as Caucasian (90, 90%), followed by Asian American (2%), then Hispanic/Latino (1%), multiracial (4%), and "other" (3%). No participants identified as African American/Black, American Indian, Alaskan Native, Arab/Middle Eastern or Pacific Islander.

A majority of participants (57%) indicated a Master's degree as their highest level of education, 30% completed a Bachelor's degree, 5% completed a Doctorate, and 9% of participants indicated "other professional training" as their highest level of education. Participants' years in practice ranged from one year to 44 years, with an average of 20 years' experience for the entire sample. Participant certifications were as follows: Certified Rehabilitation Counselors (CRC) (57%), Certified Case Managers (CCM) (24%), Certified Disability Management Specialist (CDMS) (23%), case manager (19%), Registered Nurse (RN) (18%), other (18%), Licensed Professional Counselors (LPC) (17%), rehabilitation provider (11%), career counselor (11%), American Board of Vocational Experts (ABVE) (5%), psychological counselor (2%), licensed clinical social worker (2%), certified substance abuse counselor (2%) and life-care planner (1%).

Most participants reported working in suburban settings (52%), urban settings (49%), and rural settings (25%). Participants were able to select multiple geographic locations to reflect the diversity of Ohio's geographic landscape. As for state of licensure, 48 participants held licenses in Ohio, five participants were licensed in Ohio as well as in another state (MD, PA, KY, MI), one participant was licensed both in Ohio and nationally, three participants indicated that they were only certified nationally with CRC, CDMS, or CCM certification and four participants responded "not applicable."

Data Collection and Measures

Data was collected from rehabilitation counselors in Ohio via an online survey, comprised of eight demographic questions and 28 Likert-type questions, and four open ended questions. The survey instrument was created through the collaboration of 15rehabilitation counselors as part of a Delphi Panel. The purpose of the Delphi method is "to elicit perceptions or judgments held by experts who are knowledgeable in a specialized area. The opinions are then refined through subsequent reviews, with the eventual outcome being a converging consensus about a given subject" (as cited by Vázquez-Ramos, Leahy, and Hernández, 2007, p.112). After completing three rounds of feedback and changes, panel members with a range of seven to 34 years of experience, including an average of 25 years of clinical experience, agreed upon the content of the survey.

Participants received the survey via an email invitation provided by Survey Gizmo. The researchers configured this web-based application so that no IP addresses, email addresses, or identifying information will be collected or stored. All electronic transmissions both outgoing and incoming from Survey Gizmo servers were protected by SSL encryption. Once the data was collected it was exported into SPSS 19.0 for statistical analysis.

Data Analysis

Responses were downloaded from Survey Gizmo into Microsoft Excel and then imported into SPSS 19.0 for further analysis. Descriptive statistics were analyzed for each of the demographic variables including gender, race, education level, state of practice, location of practice, gender, age, ethnicity, years of experience, highest degree earned, certifications held, and work location. Qualitative data were extracted from responses to four open-ended questions. Participants were permitted the option to not respond to all questions. There were 99 responses to the first open-ended questions (Describe how the proposed VR provider fee schedule could affect VR services for injured workers.). The second open-ended question (Describe how the proposed VR provider fee schedule could affect the duration of VR services offered to injured workers) elicited 98 statements. The third question (Describe the ethical challenges you may foresee with the implementation of the proposed provider fee schedule) elicited 99 responses. The final question of the survey allowed the participants to provide "any additional thoughts or feedback." This question was answered by 56 participants.

The qualitative coding process was competed in multiple steps and coded by three independent raters. All qualitative data was entered into the qualitative software NVivo 10. This software was used to organize and code the qualitative data. Inter-rater reliability was used to assess the degree to which different raters agreed or disagreed in their assessment decisions. Where there were different responses, an agreed upon process and discussion were used to develop consensus. These data were initially organized and coded into four major themes based on the raw responses to the open-ended questions. A second coding analysis on the data was performed to further organize the statements into sixteen themes.

Results

Quantitative

Over 90% of participants agreed with the following statements: If an injured worker dies, is deemed medically unstable, settles his/her claim or in some way drops out of services, he/she should not be included in the statistics used for tally outcomes for providers (95%, M=3.71, SD=.627); a VR-OBFS will result in fewer injured workers entering plans as they will be deemed non-feasible as opposed to being given a chance to succeed (93.90%, M= 3.51, SD= .734); and if given the choice, case managers may reject high complexity cases in an effort to avoid lowering their RTW rate (93%, M=3.41, SD=.845).

Over 80% of participants agreed with the following statements: Complex cases will be less likely to get services from providers if a VR-OBFS is implemented (87.9%, M=3.32, SD=.87); a VR-OBFS will create ethical issues in provision of rehabilitation services to injured workers (86.9%, M=3.38, SD=.842); if providers are on a VR-OBFS, then managed care organizations (MCOs), doctors, BWC staff and all treatment providers involved should also be on this type of OBFS (86.80 %, M=9.39, SD=.956); a VR-OBFS will result in case managers/job placement service providers leaving the field (85.8%, M=3.23, SD=.793); a VR-OBFS could present an ethical conflict given the provision of similar services for different injured workers at different pay rates (84.9%, M=3.35, SD=.896); more importance will be placed on securing the RTW than providing the injured workers all the services they need for the best

possible outcome (84.9%, *M*=3.30, *SD*=.974); injured workers with acute medical/psychological impairments will have an increased difficulty recruiting a service provider as a result of a VR-OBFS (83.9%, *M*=3.19, *SD*=1.00); and a VR-OBFS will affect injured workers' access to services (81.8%, *M*{plain =3.24, *SD*=.98).

Over 70% of participants agreed with the following statements: pre-determined plan time frames will limit the length of services offered to injured workers so that the maximum outcome pay can be received by securing a RTW within the allotted time frame (77.7%, *M*=3.02, *SD*=.926); if an OBFS is implemented then providers should have 100% authority over the treatment plan in terms of which services an injured worker needs and will receive (76.7%, *M*=3.14, *SD*=1.14); injured workers' interests will be limited in favor of RTW options that may be contrary to their best interests so that the provider can receive outcome pay (75.8%, *M*=3.04, *SD*=.99); a VR-OBFS will affect the quality of services provided to injured workers (72.7%, *M*=2.93, *SD*=1.15); and if their complexity increases in the middle of a plan case managers may be tempted to transfer the case so it does not affect their RTW rate (62.7%, *M*=2.74, *SD*=.996).

Over 60% of participants believed that a VR-OBFS will impact their client selection process (62.6%, *M*=2.67, *SD*=1.24). Over 50% of participants agreed that a VR-OBFS will affect injured workers' RTW rates (54.60%, *M*=2.3, *SD*=1.31) and they would not accept a transfer case if it is a high complexity case as it could adversely affect their RTW rate and outcome pay (52.54%, *M*=2.47, *SD*=1.21).

Over 50% of all participants either agreed or strongly agreed with every statement on the survey. Only one statement had less than 50% agreement: 49.5% of participants believed that VR-OBFS will alter the way they provide services more so than the way they choose which clients they would be willing to work with (49.5%, *M*=2.41, *SD*=1.23).

Qualitative

After a thorough review of the qualitative data, the following four primary themes were identified: effect on case selection, effect on time-frames, effect on services, and ethical concerns. From there, the following sixteen sub-themes emerged and were later used to code participants' responses to the open-ended questions: cherry picking, complex cases, emotional response, independent providers/MCOs, leaving the field, lengthen timeframe, shorten timeframe, no changes, positive changes, not in best interest of the client, quality decrease, rural concerns, suggestions for change, impact on training, and ethical concerns.

The percentages that are reported reflect the proportion of responses related to the sixteen identified themes. Percentages do not add up to 100% due the authors' choice to allow responses to relate to multiple themes to reflect the rich diversity of the data. The first open-ended question (Describe how the proposed VR provider fee schedule could affect VR services for injured workers.) had a response breakdown as follows: not in best interest of the client (90.77%), ethical concerns (77.65%), cherry picking (61.26%), complex cases (61.71%), services based on outcomes (59.51%), independent providers/MCOs (28.94%), quality decrease (5.57%), suggestions for change (3.54%), impact on training (2.39%), rural concerns (1.02%), emotional response (1%), leaving the field (.44%), an no responses were related to lengthened timeframes.

The second open-ended question (Describe how the proposed VR provider fee schedule could affect the duration of VR services offered to injured workers) had a response breakdown as follows: complex cases denied (52.8%), shorten timeframe (47.73%), services based on outcomes (16.6%), not in best interest of client (9.76%), independent providers/MCOs (7.90%), unethical (7.49%), lengthen timeframe (7.15%), quality decrease (5.12%), emotional response (2.82%), impact on training (1.42%), rural concerns (1.34%), no changes will result (1.21%), suggestions for change (0.55%) and cherry picking (0.31%). No responses related to leaving the field of VR (0%) or positive changes (0%).

The third open-ended question (Describe the ethical challenges you may foresee with the implementation of the proposed provider fee schedule) had the following response breakdown: unethical (51.03%), complex cases denied (26.27%), rural concerns (15.28%), emotional response (13.65%), not in best interest of client (11.5%), services based on outcomes (9.39%), independent providers/MCOs (7.56%), cherry picking (6.9%), quality decrease (5.8%), leaving the field of VR (5.08%), impact on training (4.62%), shorten timeframe (4.41%), no changes will result (4.28%), positive changes (0.92%), suggestions for change (0.34%). No responses were related to the lengthened timeframes (0%).

The final open-ended question of the survey allowed the participants to provide "any additional thoughts or feedback." The response breakdown was as follows: ethical concerns (16.45%), leaving the field (5.08%), suggestions for change (4.42%), shorter timeframes (4.41%), not in best interest of client (5.13%), emotional responses (3.67%), positive changes (2.62%), rural concerns (1.43%), quality decrease (1.34%), complex cases denied (1.23%), cherry picking (.81%) and independent providers/MCOs (0.05%). No responses related to services based on outcomes (0%), impact on training (0%), longer timeframes (0%), no changes (0%), services based on outcomes (0%), impact on training (0%),

Discussion

Question 1. How Would the Proposed VR-OBFS Affect VR Services for Injured Workers?

Case selection.

Both the quantitative and qualitative data support the notion that VR professionals agree that the proposed VR-OBFS will affect services for injured workers. The overwhelming trend in the qualitative responses was that participants foresee the need for "cherry-picking" their cases based on expected RTW outcomes. Participants explained a concern that managed care organizations (MCOs) may be able to "pick and choose" rehabilitation providers for optimal RTW production with only the IWs who are "most likely" to return to work accepted. Participants wrote, "IWs will have fewer provider choices or none at all. Fewer cases going to job placement and job development (JPJD) when the complexity is high will result in fewer services for the IW."; "Complicated cases will be "weeded out.", "Providers may "cream for easy cases" for RTW and outcome pay"; "IWs will be forced into non-ideal jobs just for the RTW outcome, which may lead to more re-referrals."

Some participants explained their fear that rehabilitation services will be denied or less accessible to IWs with complex cases. The quantitative findings reveal this concern as over 90% of participants agreed that a VR-OBFS will result in fewer injured workers entering plans as they will be deemed non-feasible as opposed to being given a chance to succeed. The quantitative results also indicated that over 90% of participants agreed that if given the choice, case managers may reject high complexity cases in an effort to avoid lowering their RTW rate and that complex clients will be less likely to get services from providers if a VR-OBFS is implemented.

When asked how a VR-OBFS will personally impact how they work with cases, over 60% of participants reported that a VR-OBFS will impact their client selection process and that if the complexity increases in the middle of a plan case managers may be tempted to transfer the case so it does not affect their RTW rate. Participant responses included, "More emphasis will be made on selecting injured workers who are more employable, have more transferable skills and who are more likely to RTW without needing lengthy training or job readiness in terms of adjustment or career counseling services."

Some participants feared that the proposed fee schedule could result in a shift in which type of provider (MCO vs. independent VR provider) will take on cases with higher complexity. One participant wrote, "An MCO that owns a rehabilitation company will select individuals with minimal restrictions and refer those clients to their own company. Complex cases will be assigned to independent VR case managers, or will be determined to be medically unstable or not feasible." One participant summarizes this sentiment: "Simply put, the population of IWs that most need VR services because of barriers will be adversely impacted as VR providers will be unwilling to work complex cases." Participants detailed this thought process: "If everyone deserves a chance to succeed but giving them the chance cuts my pay 30% should I accept them as a client?", "I would not be happy about taking on more complex cases or IW's that have no GED, no valid driver's license, a felony record etc. as these are barriers to RTW now and more so if fee schedule is implemented", "I would have to choose between making money and staying solvent and doing what is in the best interest of the injured worker."

The quantitative findings indicated that the statement agreed upon by the largest percentage of participants was related to the situation in which an IW is deemed medically unstable, settles his/her claim, or in some way drops out of services. Over 95% of participants agreed that the IW should not be included in the statistics used for tally outcomes for providers. Nearly the entire participant sample agreed with this statement reflecting the concern that their RTW rate would be negatively affected by IW issues that are "beyond their control." Issues mentioned in participant responses included: settlement, the need for additional surgeries or ongoing medical treatment, physical therapy, or occupational therapy resulting in time when IWs are not available for rehabilitation services, etc.

Rural concerns.

The qualitative data revealed a specific concern for IWs located in rural areas. A participant wrote, "Injured workers in the rural areas are NOT on the same playing field as those injured workers in the metro areas or injured workers living in metro areas." Another participant detailed this specific concern: "Working in rural area does takes a while to obtain successful RTW. One rural employer may have one job opening and have over 125 applicants applying for the position." Another participant explained the impact that a fee schedule may have for IWs in his or her rural area:

"I work in a depressed rural area of Southern Ohio; I am one of only a few case managers who works in this area. Two case managers in my area have left the field due to the new fee schedule. A large part of my referrals are brain injury cases. They are always more complex and time frames are greatly extended in comparison to typical VR referrals. This would certainly seem to affect my ability to provide the most appropriate care to these individuals. IW will not receive the quality of services that they deserve."

Positive changes.

Not all responses were negative as some participants felt that the proposed fee schedule may usher in positive changes in the field of VR. The qualitative data details some of the positive consequences of the change. The quantitative data, however, does not reflect this potential outcome. Participants wrote, "Focus will be on efficient RTW not padding the billing cycle with extra activities to make more money.", "We hope it will help provide an incentive for QUALIFIED providers to use their professional expertise to determine IWs who truly have a RTW goal versus those advised by their attorneys to remain on compensation as long as possible." Some participants did not mention positive changes but noted that they believed that ethical VR providers will not be impacted by a change in fee schedule. Other participants felt that the fee schedule changes may reduce the duration of services to injured workers as a result of a better up front professional assessment of their "real" needs. One participant wrote, "CMs may extend services for reasons such as improved physical/functional abilities to increase the chances of successful RTW. IWs and case managers will need to work together for a successful RTW. The case manager now has some skin in the game. No more lazy stuff."

Research Question 2: Would a VR-OBFS Affect the Duration of Services Offered to Injured Workers?

Duration of services.

The overwhelming response to how the proposed fee schedule will impact the duration of VR services was related to the shortening of VR plans in order to accommodate a sole focus on RTW. Over 70% of participants agreed with the following statement: "pre-determined plan time frames will limit the length of services offered to injured workers so that the maximum outcome pay can be received by securing a RTW within the allotted time frame." In the qualitative data, nearly 70% of responses to the open-ended question related to how a VR-OBFS will result in shortened timeframes. Only 7% of responses indicated longer timeframes and only 1% of participants believed that there wouldn't be any change to the duration of services offered.

The research literature to support these findings indicates that operating under an outcome-based fee schedule could pressure rehabilitation counselors into moving forward with service plans too rapidly or before the client is medically stable (i.e., reaching maximal medical improvement), and, as a result, the trusting alliance between counselor and client may be impeded (Hagglund & Frank, 1996; Lane et al., 2012). The findings of the current study directly reflected these concerns. One participant wrote, "IWs would be hurried through services, to keep expected timelines, without giving the needs of the individual the sole consideration. In the long run, long term outcomes may decrease, even though short term outcomes may increase."

Some participants predicted that case managers may "over-project" the length of services to try and ensure a successful outcome, i.e. anticipated (projected) service duration will be inflated to capture all unexpected delays or interrupts so outcomes is not negatively affected. One participant detailed, "In order to stay in business service providers will likely shorten/amend length of services to be more appropriate for the outcome based fee but schedule, this eliminating opportunities to take full benefit of services and will only receive 'bare bones' programs."

Research Question 3: How do Rehabilitation Counselors Describe the Ethical Considerations That Could Potentially Occur as a Result Of The Implementation of a VR-OBFS

The Commission on Rehabilitation Counselor Certification (CRCC) is committed to advocating for both its Certified Rehabilitation Counselors (CRCs) and the profession of rehabilitation counseling (2014). The mandatory standards delineated in the *CRCC Code of Professional Ethics for Rehabilitation Counselors* (2010) are intended to assure the community that the rehabilitation counseling profession accepts its responsibility to provide caring, competent and ethical services to individuals with disabilities (CRCC, 2010). The Preamble states, "Regardless of the specific tasks, work settings, or technology used, rehabilitation counselors demonstrate adherence to ethical standards and ensure the standards are vigorously enforced" (CRCC, 2010, p. 1). Section F.4.a of the CRCC Code of Ethics states, "Rehabilitation counselors do not enter in financial commitments that may compromise the quality of their services or otherwise raise questions as to their credibility . . . . Payment is never contingent on outcome or awards." (CRCC, 2010). The findings of the current study highlight VR professionals concerns that a VR-OBFS may prevent them from working within the ethical guidelines that they are required to uphold.

Best interest of the IW.

Several participants detailed their concerns that a focus on RTW was not in best interest of IWs, specifically noting the potential for limitations on the accessibility and detriments to the quality of services provided for IWs. The most resounding theme in all of the qualitative data was related to concern that a VR-OBFS was not in the best interest of the IW. Over 90% of responses to the first open-ended question included (or were related to) some variation of the term

"not in best interest of IWs." Over 75% of the responses to the first open ended question included the term "unethical" and over 50% of the responses to the third open-ended question related to ethical concerns included the term "unethical." One participant wrote, "RTW based on pushing IWs to RTW in ANY job, is not addressing problems and creates a revolving door. Case managers may put a client into a position outside of the client's restrictions just to get them back to work quickly or not consider any sort of training."

Access to training also emerged as a potential consequence: "There will be less access to training due to pressure to RTW in short time frame. Fewer IWs will receive services, and said services may not be comprehensive in nature." Several participants made statements regarding how the proposed fee schedule may have an effect on the emotional wellbeing of their clients. Prior research that illuminates the perspectives of clients indicates that the most ideal service providers in rehabilitation counseling were often characterized as "client advocates" (McCarthy & Leierer, 2001; Wagner et al., 2011). One participant wrote, "A counselor develops a rapport with IW's and their families. We know about their kids, grandkids, hobbies etc. We are often the first ones to gain their trust b/c we are one of the few providers they see on a regular basis. I'm concerned about how the proposed fee schedule will affect them emotionally and personally if I have to decline a case simply b/c I can't guarantee they will go back to work."

Wagner, Wessel, and Harder (2011) highlighted the importance of the "working alliance" between professionals and clients (p. 46). They noted that a major concern of clients was their service providers' investment in their needs. Clients often held the "working alliance" in high regard with the particular need for feeling respected, professionalism on the part of the counselor, and advocacy. Using the perspective of rehabilitation counselors, Lane, Shaw, Young, and Bourgeois (2012) explained that pressures from the workplace environment hindered the ability to develop stronger counseling relationships that would facilitate rehabilitation for clients.

Ethical dimensions.

The majority of participants wrote responses explaining why they believed the propose fee schedule is unethical. Participants wrote: "Ethical CMs that do not allow the outcome based schedule to dictate their case choices, will be penalized for their convictions to accept cases when the difficulty/complexity is high.", "No consideration is given on how devastating this can be to people who are trying desperately to get back on their feet. We are treating clients as "files" and not as persons who have very complex situations that need to be addressed. This approach is simply wrong."

Several participants reflect on the ethical conflicts between the proposed fee schedule and the CRCC Code of Ethics: "CRCs are not permitted to take a commission to provide services to clients. The fee schedule is set up to provide a commission to rehabilitation counselors. It puts CRCs in a situation where they will have to go against their code of ethics." Some participants responded with questions related to ethical concerns: "How is due process in VR been removed from the law?" One participant referred to the fee schedule as a "draconian move" in that "payment becomes the first consideration, not the needs of the IW", "This structure suggests a pay cut with promise of a bonus at the end will somehow enhance RTW rates but not ethical decisions", "More attention to the dollars and not on the clients. People are VERY diverse and cannot not be considered for "cookie-cutter" rehab." One participant asks, "If a case manager's income is based on a fee schedule, then what is the incentive to provide services to complex clients or cases that are outside of the box? Has this job become more about money or is it really about helping injured workers?" These responses echo the concern that economic factors will influence counselors' ethical principles significantly decreasing their ability to be an advocate for people with disabilities.

Financial consequences.

Participants detailed how the financial consequences of the proposed fee schedule may personally impact their clinical decision making process. Over 85% of participants believed that a VR-OBFS will create ethical issues in provision of rehabilitation services to injured workers and could present an ethical conflict given the provision of similar services for different injured workers at different pay rates. Over 90% of participants agreed that a VR-OBFS will result in fewer injured workers entering plans as they will be deemed non-feasible as opposed to being given a chance to succeed and if given the choice, case managers may reject high complexity cases in an effort to avoid lowering their RTW rate. Over 50% of participants agreed that a VR-OBFS will affect injured workers' RTW rates and they would not accept a transfer case if it is a high complexity case as it could adversely affect their RTW rate and outcome pay.

Participants wrote, "Our focus will mainly be on making a living to financially survive; not on quality services.", "More complex cases require more hours, if I don't feel a client will be successful I will be tempted to offer fewer direct services/shorter durations of programs again out of fear for not being reimbursed fully for my work hours." Another participant wrote, "Obviously, if a case is deemed too difficult for whatever reason it will be closed...Under the proposed fee schedule, I will be more likely to close those individuals in a "gray" area due to fear of losing pay for the hours I've worked." There was a clear concern that "second chances" will not be allowed, and closures for non-compliance will increase. A participant wrote,

"My service recommendations may not be approved yet I will be the one penalized by pay rate. Feel we are being the scape goat on both sides." Overall, participant responses indicated that there will be a shift from client based needs to cost containment strategies thus negatively impacting the quality of vocational rehabilitation services delivered.

Over 85% of participants agreed that a VR-OBFS may result in case managers/job placement service providers leaving the field. Approximately five participants made statements related to their intention to leave the field if the proposed fee schedule takes effect: "I won't be in the bind this creates. I'll quit first. The benefit of the doubt that is part of decisions about the projected capacity to benefit from services (feasibility) will be given to my pocketbook and not the IWs program to restore vocational wholeness."

Limitations

Although efforts were taken to utilize sound mixed-method methodology, several limitations should be taken into consideration. The first limitation of the current study relates to the research sample and the study's external validity. Although the sample size of this study (N=100) was appropriate for the analyses completed, a larger sample would increase the generalizability of the findings. Additionally, this sample was comprised of VR professionals from Ohio and can only be extrapolated within Ohio and not to other states or to the nation as a whole. Other states or a nationwide sample would have a different demographic breakdown than the current study's sample as it included primarily Caucasian participants.

A second potential limitation related to the sample is self-selection bias. The VR professionals who did not respond to the survey may have different opinions as compared to those reported in the present sample. Self-selection bias occurs when the group being studied has any form of control over whether to participate. Participants' decision to participate may be related to traits that could potentially impact the study, thus, the participants who completed the survey may be a non-representative sample. Oftentimes, people who have strong opinions or increased knowledge in a particular subject area may be more eager to respond to a survey as opposed to those who are less interested in the nature of the subject matter.

The final limitation is the lack of generalizability inherent in the nature of qualitative research. This was an exploratory study and therefore, we utilized qualitative methods as a way to delve deeper into a topic that has had only a minimal amount of prior research. The data collected were obtained via self-report which is also understood as a potential threat to validity.

Conclusion

The findings of this study reveal a multitude of concerns related to how vocational rehabilitation providers and IWs may be affected if a VR-OBFS is implemented. The findings of the current study suggest that a more thorough examination, informed consideration, and collaboration needs to occur among practitioners, IW's and the Ohio BWC *before* a VR-OBFS is implemented. Concerns related to how rural areas will be affected, the financial consequences, complex case selection, and the ethical dimensions of the policy need to be considered. Ultimately, VR professionals expressed fears that the best interest of the IW will no longer be the sole focus of treatment and, as a result, a VR-OBFS would sanction a direct contradiction to the CRCC Code of Ethics.

Further research assessing how IWs experience care under this policy, how providers are affected, the financial implications, and how VR professionals across the United States may be impacted by a VR-OBFS will allow for a deeper understanding of the complexities that may result from a fee schedule based on outcomes. If implemented in Ohio and if other states follow, a VR-OBFS could potentially have a similar effect to how managed care impacted the medical profession and practitioners in the 1980s and 1990s. A more thorough consideration of how a VR-OBFS could affect independent VR practitioners who are not employed by large companies is needed. A national study done in conjunction with International Association of Rehabilitation Professionals (IARP) and the American Board of Vocational Experts (ABVE) will enable a fuller understanding of the far reaching implications of this policy change on the rehabilitation counseling profession.

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