Chapter 6
Operations: Rehabilitation Division
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The Effectiveness of Rehabilitation

RESEARCH ON EFFECTIVENESS

Rehabilitation forms a major part of most workers’ compensation systems. And while most of the literature the commission reviewed suggests that “vocational rehabilitation mitigates the disabling consequences of workplace injuries with respect to returning the injured worker to employment;” measuring its effectiveness is elusive and controversial. A number of researchers have pointed out that rehabilitation can be expensive and it is by no means certain the costs can be justified by the results. For example:

• What determines a successful intervention? What is the appropriate measure of success? Is it:
  - the degree of medical recovery or the success of a return to work?
  - the extent to which a worker is able to attain the lifetime earnings profile that would have been expected had the injury not occurred? or
  - the cost-effectiveness of the intervention, a concept which is itself difficult to define?
• When should the measurement be made?
There is both a lack of comparable research (particularly of the long-term effects of rehabilitation), and a lack of agreement on common definitions within the research. In fact, the enormous variability between jurisdictions, in terms of such things as eligibility and delivery, make comparisons very difficult. The issue of “attribution” further compounds this problem: What part of a recovery, or failure to recover, is due to vocational rehabilitation services, and what is due to other factors?

In general, according to a 1995 report entitled *Unfolding Change: Workers’ Compensation in Canada*:

> researchers have not attempted to address this critical issue. Instead, they have chosen their own measure of success and tried to evaluate the influence of vocational and medical rehabilitation interventions on achieving the successful outcome. Economists have tended to measure success by the return to employment and the size of post-injury earnings. Medical researchers have concentrated on physiological measures, while sociologists have considered effects on personal and family lives.

To this list of economists, medical researchers and sociologists could be added the choices of any number of groups affected by rehabilitation service, including interest groups able to influence service delivery either directly (e.g., through shared governance of the compensation system) or indirectly (e.g., through the media).

**RETURN TO WORK**

The Workers’ Compensation Board has chosen return to work as the primary indicator of the effectiveness of its rehabilitation programs. In the *1996 Strategic Plan*, the panel of administrators made “to assist in returning injured workers to work through medical care and vocational and clinical rehabilitation,” the second most important objective of the board after prevention. The panel has made it an objective of the board to “improve the safe return to work rate for workers with permanent disabilities by 10% by [the year] 2000.”

While this commission endorses return to work as one of the most important objectives of the workers’ compensation system, there are currently a number of difficulties inherent in using it as a performance measure. It is extremely difficult to control for more than a few of the non-rehabilitation factors which influence return to work. These factors include, but are by no means limited to:

- the method of service delivery;
- the criteria for eligibility;
• the worker’s characteristics;
• the worker’s relationship to the workplace at the time of injury;
• the willingness of the employer to accommodate the worker;
• prevailing conditions in the labour market;
• co-workers’ perceptions of injured workers; and
• incentives and disincentives such as taxes and program design.

Even in cases where return to work can be demonstrated, attribution is not always clear. For example, the board’s 1994 evaluation of back-injured workers entitled Vocational Rehabilitation Interventions Evaluation Study found that only 43% of the workers who returned to work “credited the board’s vocational rehabilitation services with helping them to find or keep the job they returned to.” There are similar findings in other studies.

Of even greater concern to the commission is the fact that, although the board is quite public in its use of return to work data to indicate the success of its strategies and programs, the information on which it bases its comments appears to be unreliable and possibly flawed. For example, the databases for collecting outcome data, including the current Rehabilitation Performance Management (RPM) system, have had a number of problems of which board management is fully aware. These include:

• an inconsistent use of the closure codes by vocational rehabilitation consultants for data entry, raising concerns about the reliability of reporting;
• a lack of definitions for “safe and durable return to work;”
• a lack of differentiation between new cases and re-openings or re-referrals of previous cases, creating a potential for counting more than one return to work for the same individual for one claim. For example, if an injured worker returns to work in January but is unsuccessful in that attempt, returns to vocational rehabilitation for further services in February, and then repeats the cycle later in the year, that is reported as three returns to work, even though only one individual is involved and even though at least two of these returns to work cannot be described as successful;
• a potential for the board to double count returns to work for individuals who are seen by vocational rehabilitation consultants in the Rehabilitation Centre; and
• instances of returns to work and retraining being reported as one item.

Apart from the fact that the board has not defined either safe or durable return to work in the context of vocational rehabilitation services, the department does not conduct follow-up interviews with clients (or employers) after they have
returned to work, to determine the length of time they remain working or in a specific job, or whether they have to change jobs or duties due to health reasons, or to quit working. Recent research suggests that a one-time measure of return to work, either at the end of services or shortly thereafter, is not an accurate assessment of return to work. Follow-ups are conducted only for workers who receive Rehabilitation Centre services and similar services offered by external providers.

Only since late 1996 has the board been collecting data in a systematic way on the reason for referral to the Vocational Rehabilitation Services Department. While there are concerns regarding the way this is determined, the board considers return to work to be a realistic outcome for 65 to 70% of referrals. Using this estimate, total referrals to the Vocational Rehabilitation Services Department and total “returns-to-work” for 1997, it appears that approximately half of those for whom a return to work is a “realistic” outcome actually do return to work; however, there is no benchmark against which to assess this rate.

The only firm data on return-to-work outcomes for the Vocational Rehabilitation Services Department identified by the commission are presented in the 1994 Vocational Rehabilitation Interventions Evaluation Study of back-injured workers. This evaluation suggests that for a significant proportion of the population surveyed, the return to work was neither safe nor durable. The study surveyed 568 workers who recalled receiving services as a result of their referral to the Vocational Rehabilitation Services Department. Of these 568 workers, 333 (59%) reported that they returned to work during rehabilitation or when their vocational rehabilitation interventions finished.

Of the 333 workers in the study who returned to work, 52% stated that the services they received “did not help them to return to these jobs at all.” Employers were somewhat more positive. Seventy-four percent of the 64 employers surveyed who recalled workers who had returned to work, agreed that the Workers’ Compensation Board’s vocational rehabilitation services helped achieve this outcome.

At the time of the survey:

- less than half (45%) of the 333 workers who had returned to work were still working in the job to which they returned; and
- 184 (55%) were either working in other jobs or were not working at all:
  - 32% had remained over one year;
  - 17% had remained between seven and 12 months; and
  - 47% remained six months or less.
Seventy percent of the 184 were no longer in the jobs they returned to, because injury or illness made it too difficult to perform the job (54%), or because of too much pain (16%). Less than half (40%) reported that they had been employed most, or all, of the time since ready to return to work, and 15% reported that they had been employed about half the time.

Of the workers who returned to work:
• 57% returned to the same wage level;
• 13% went to higher wage level; and
• 28% went to lower wage level.

Given the problems identified above, the board’s return-to-work figures could be misleading. Newspaper clippings report senior managers at the board quoting improved return to work rates; however, there may be little justification for confidence in the numbers they present until these problems are resolved. This lack of accurate data not only inadvertently misleads the public, it also has implications for program development, resource allocation and public accountability.

TYPES OF REHABILITATION

Rehabilitation can be separated into two major fields: physical and vocational. Vocational rehabilitation is provided to workers with compensable injuries or diseases that have affected their ability to return to their pre-injury employment. In general, an injured worker receives vocational rehabilitation (assistance in returning to the pre-injury job or in finding alternative employment) once the worker’s medical condition has “plateaued,” although some services may be provided before or after this date. It is becoming increasingly recognized that early intervention is an important factor in successful rehabilitation.

Return to work is an expected outcome for most, but not all, workers who are referred to the Vocational Rehabilitation Services Department. For example, clients may be referred for quality of life services (e.g., counseling for dependants, home support) or for services in support of pension assessments (i.e., employability assessments).

The human costs of disability can be substantial. These can include loss of self worth, marital and family stress, financial strain, and depression. The longer a disabled worker remains outside the workforce, the less likely he or she will be to eventually return. Various factors, such as increasing age, poor education, and lack of transferable skills, will make vocational rehabilitation efforts even more difficult. The financial costs to the system of workers remaining on compensation, rather than returning to work on a part-time or full-time basis, are also substantial.
There have been major changes in the British Columbia and global economy in the past 20 years. Provincially the most important changes include a shift from resource-based to service- and technology-based industries, an increase in self-employment and part-time work, an increase in the role technology plays in the workplace, an increase in the number of women in the workforce, and a general aging of the workforce. All of these changes have profound implications for the workers’ compensation system.

In order to meet these challenges, most workers’ compensation systems in the western world have undertaken a variety of reforms. Generally, the intended outcome of these reforms has been a greater emphasis on prevention and rehabilitation as a way to reduce costs and foster early return to work. The results of these reforms have not always been viewed as equitable or successful. Nor are the dual purposes of reduced costs and early return to work always seen as compatible or appropriate.

The practice of “deeming,” the durability of return to work, the mandate for vocational rehabilitation and the measurement of outcomes and funding (issues common to other jurisdictions) were all raised by participants in this process.

Costs for vocational rehabilitation services provided by the board rose dramatically in the early 1990s, raising a number of concerns among employers. Recent efforts to contain these costs resulted in changes in practice within the board, and have been criticized by workers.

In order to inquire into these “recurring and current issues pertaining to the operation and administration of rehabilitation and re-employment matters,” as described in its Terms of Reference, the commission combined audit, program evaluation and performance measurement techniques. These techniques were supplemented by a limited amount of peer review/expert opinion.

Researchers for the commission collected data from a variety of sources including:

- literature and document reviews;
- submissions to the commission;
- questions directed to the Workers’ Compensation Board; and
- interviews with board staff and non-board personnel.

The first two items alone amounted to more than 600 working papers, several compact disks, and approximately 140 submissions to the commission which in some way addressed rehabilitation matters.
The board relies on four program areas to meet its rehabilitation responsibilities. These are: Vocational Rehabilitation Services, Medical Services, Psychology Services, and the Leslie R. Peterson Rehabilitation Centre (the Centre). The commission refers to the four program areas as “rehabilitation services;” however, the four areas are not grouped together within the board. The Vocational Rehabilitation Services Department is within Compensation Services Division, while the other three areas form the Rehabilitation Division. The Compensation Services Division and the Rehabilitation Division comprise the Rehabilitation and Compensation Services Divisions.
Vocational Rehabilitation Services

MANDATE, MISSION, STRUCTURE AND STRATEGIES

Legislation

The board provides vocational rehabilitation services to approximately 8,000 workers per year. These workers have been on short-term disability benefits for varying lengths of time, and some of them will go on to receive long-term disability benefits or pensions.

Section 16 of the Workers Compensation Act is the guiding legislation of the Vocational Rehabilitation Services Department. It states:

(1) To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap, the board may take the measures and make the expenditures from the accident fund that it considers necessary or expedient, regardless of the date on which the worker first became entitled to compensation.

(2) Where compensation is payable under this Part as the result of the death of a worker, the board may make provisions and expenditures for the training or retraining of a surviving dependent spouse, regardless of the date of death.

(3) The board may, where it considers it advisable, provide counselling and placement services to dependants.

This section makes it clear that the board provides vocational rehabilitation services at its discretion. While this may be appropriate in the case of injured workers, the commission, in its October 1997 Report to government on Sections 2 and 3(a) of its terms of reference, recommended that in the case of surviving spouses and dependants:

s.16(2) be amended to provide that, where such services have been requested and a need has been determined, ‘the board shall make provisions and expenditures for the training or retraining of a surviving dependent spouse, regardless of the date of death’; and

s.16(3) be amended to provide that, where such services have been requested and a need has been determined, ‘the board shall provide counselling and placement services to dependants’.

To date, government has not acted on these recommendations.
Mission

Quality of rehabilitation has been a key component of the board’s Mission Statement since at least 1991:

Workplace safety and heath is our challenge. Quality rehabilitation and fair compensation is our commitment. World leadership is our goal.

This is reflected in the Vocational Rehabilitation Services Department’s mission statement which, according to its 1998 Business Plan is:

To provide quality interventions and services to assist our clients in achieving durable return to work and other appropriate rehabilitation outcomes with a focus on shared responsibility.

Chapter 11 of the Rehabilitation Services and Claims Manual (the Manual) sets out the policies governing the provision of vocational rehabilitation services. Paragraph 85.20 defines quality vocational rehabilitation:

Quality rehabilitation requires individualized vocational assessment, planning, and support provided through timely intervention and collaborative relationships to maximize the effectiveness of rehabilitation resources and worker-employer outcomes.

Chapter 11 of the Manual also acknowledges three objectives of the department and seven principles to guide quality vocational rehabilitation. The objectives are:

1. To assist workers in their efforts to return to their pre-injury employment or to an occupational category comparable in terms of earning capacity to the pre-injury occupation.
2. To provide the assistance considered reasonably necessary to overcome the immediate and long-term vocational impact of the compensable injury, occupational disease or fatality.
3. To provide reassurance encouragement and counselling to help the worker maintain a positive outlook and remain motivated toward future economic and social capability.

The guiding principles are:

1. Vocational rehabilitation should be initiated without delay and proceed in conjunction with medical treatment and physical rehabilitation to restore the worker’s capabilities as soon as possible.
2. Successful vocational rehabilitation requires that workers be motivated to take an active interest and initiative in their own rehabilitation. Vocational programs and services should, therefore, be offered and sustained in direct response to the commitment and determination of workers to re-establish themselves.
3. Maximum success in vocational rehabilitation requires that different approaches be used in response to the unique needs of each individual.

4. Vocational rehabilitation is a collaborative process which requires the involvement and commitment of all concerned participants.

5. Effective vocational rehabilitation recognizes workers’ personal preferences and their accountability for independent vocational choices and outcomes.

6. The gravity of the injury and residual disability is a relevant factor in determining the nature and extent of the vocational rehabilitation assistance provided. The board should go to greater lengths in cases where the disability is serious than in cases where it is minor, including measures to assist workers to maintain useful and satisfying lives.

7. Where the worker is suffering from a compensable injury or disease together with some other impediment to a return to work, rehabilitation assistance may sometimes be needed and provided to address the combined problems. Rehabilitation assistance should not be initiated or continued when the primary obstacle to a return to work is non-compensable.

The commissioners generally endorse these guiding principles.

Vocational rehabilitation may also include preventative rehabilitation. In 1994, the board produced the Vocational Rehabilitation Services Procedure Handbook (the Handbook). It serves as a “reference guide for VRCs [vocational rehabilitation consultants] and outlines the ‘procedural requirements of the VRS, Compensation Services Division’.” This document sets out very clearly such items as policy references, purpose, process and procedure. The Handbook states that:

Preventative rehabilitation is intended to provide assistance to workers who may be physically capable of returning to the pre-injury occupation but who have been medically deemed to be at undue risk of: increased permanent disability or, permanent disability due to vulnerability.

Structure

Vocational Rehabilitation Services Department operated as a separate department within the board until 1993. In 1993, Compensation Services Division initiated a management model originally intended to result in the physical movement of services to the geographical area of the claim. However, the decentralization resulted only in a separation of claims by geographical location, while most of the offices remained in Richmond. Vocational rehabilitation consultants and claims adjudicators were then assigned to a particular Service Delivery Location (SDL) or Service...
Delivery Office (SDO), and were supervised by a Client Service Manager assigned to the location. Although there was originally to be technical support provided to the vocational rehabilitation consultants through an alternative structure, this did not occur. The Vocational Rehabilitation Services Department was effectively dissolved until the board, recognizing that lack of structure and support for the function was creating problems for vocational rehabilitation, implemented a new departmental and management structure. The rejuvenated department was established within Compensation Services Division and a new Rehabilitation Division was created. This division was to include the existing Rehabilitation Centre, Medical Department, Psychology Department, and the Vocational Rehabilitation Services Department. The plan at that time, according to the then president/CEO, was to “improve worker service by the integration of clinical and vocational rehabilitation into case management practices.”

At the present time, the Vocational Rehabilitation Services Department remains a department within the Compensation Services Division, while Medical and Psychology Services and the Rehabilitation Centre comprise the Rehabilitation Services Division.

**Strategies**

The 1995 corporate business plan presents a strategy to ensure that rehabilitation is a priority. Under the strategy, all rehabilitation activities are to be outcome oriented. Similarly, in developing the 1996 Strategic Plan, the board determined that outcome-oriented vocational and clinical rehabilitation were critical factors. The strategy had three main focal points, one of which was to: “transform service to injured workers through improved claims processes and expeditious, safe and durable RTW.” It committed to a review and, where necessary, a redesign of vocational rehabilitation programs, outcomes and systems, to improve opportunities to return injured workers to the workplace. It also states that preventative rehabilitation would continue to be provided to workers at risk of permanent disability.

The plan also states that “The Board has a clear duty to provide timely, professional, efficient service ... As a monopoly and a regulator, the Board must serve its stakeholders and the public interest in a sensitive, respectful and effective manner.”

The 1998 corporate business plan expresses generally the same objectives, strategies and outcomes/performance measures as the 1996 strategic plan.
The 1997 and 1998 (draft) Rehabilitation and Compensation Services Divisions business plans follow the corporate level plans in terms of intent. There are few new initiatives that focus directly on vocational rehabilitation (although it is involved in several initiatives, such as E-file and case management). One specific initiative is the revision of the Handbook including making it available on-line in support of the e-file initiative. New items in the 1998 plan include:

- reporting RTW as a percentage of closures with RTW as expected outcome;
- evaluating vocational rehabilitation intervention programs to ensure efficiency and effectiveness; and
- piloting the job club and preferred provider network.

Critical success factors identified for the department in its 1998 business plan include:

- successful integration of vocational rehabilitation into the case management model;
- development and management of a comprehensive external provider network;
- on-going professional development in key areas of vocational rehabilitation practice;
- monitoring and supporting clinical supervision within a matrix management model; and
- improved client satisfaction as measured through formal surveying.

Weaknesses identified in the 1998 business plan include:

- a need for better statistical reporting systems;
- an in-house lack of current local labour market information; and
- complexities associated with a decentralized department with respect to staffing and other administrative issues.

THE VOCATIONAL REHABILITATION PROCESS

Five Phases

The vocational rehabilitation process has five phases:

*Phase One:* The consultant assists the worker to return to the same job with the accident employer. Interventions at this phase may include programs of physical conditioning or work hardening, graduated return to work, work evaluation, and refresher training or skill upgrading.
**Phase Two:** If it is determined the worker cannot return to the same job, the consultant encourages and works with the accident employer to make worksite accommodations and job modification, or to provide alternative in-service placement.

**Phase Three:** If the employer is unable or unwilling to accommodate the worker, the consultant identifies suitable occupational options in the same or related industry.

**Phase Four:** If the worker is unable to return to alternative employment in the same or a related industry, the consultant explores opportunities in all industries, with emphasis placed on the workers’ transferable skills, aptitudes and interests.

**Phase Five:** If existing skills are insufficient to return the worker to suitable employment, the consultant uses training programs to enable the worker to acquire new occupational skills. In addition, the consultant assists the worker to secure employment once the training is complete.

The commission generally endorses these five phases of vocational rehabilitation.

**Employment Versus Employability**

According to all of the documents reviewed by the commission and interviews conducted by commission researchers, providing safe, timely and durable return to pre-accident employment is a primary objective of board operations. However, the Compensation Employees Union (CEU), in their submission to the commission, states that there continues to be a lack of clarity on when to conclude that all reasonable efforts to achieve employment have been exhausted, and that it is time to accept employability as the only realistic objective:

Where the confusion rests is at what point do we conclude that the first objective can not be achieved? This is the current problem and the historical problem in the employment vs. employability debate. ...There are no guidelines currently endorsed regarding an appropriate length of time to maintain a worker/client on job search benefits; for example, after sponsoring a worker through a two year B.C.I.T. program, and providing an arbitrary period of job search, VR's are not clear on whether to maintain that worker on job search benefits until actually employed, or to terminate benefits after a “reasonable” amount of time has elapsed, leaving the worker unemployed, but employable. This is one area fraught with inconsistent application on the part of VR's, [who are] given a lack of directives.
The commission recognizes the difficulty that the board has in determining when “enough is enough.” The design and outcome of a vocational rehabilitation plan will be affected by many factors, not the least of which are the severity of the compensable injury or disease, the worker’s pre-existing skills and abilities, personal interests, and availability of employment options. Clarifying what benefits can be provided under what conditions and for approximately how long would likely assist both workers and vocational rehabilitation consultants in making choices with respect to these services. Guidelines might include, for example, the approximate length of time that workers should be provided with job search benefits. According to the CEU, some draft guidelines were provided at one time based on Statistics Canada information on average length of unemployment by age group, but these were never formalized. The department might start by establishing rough guidelines (for example, on the basis of past interventions, guidelines in place in other jurisdictions), then monitoring the conditions under which they are, and are not, being met. This would enable the department to assess how realistic the initial set of guidelines were, as well as to clarify when “exceptions” could be expected to occur.

Eligibility for Services
Pursuant to Section 16 of the Workers Compensation Act, providing vocational rehabilitation services is discretionary. The board decides what vocational rehabilitation services to provide, who shall receive services, and which services they shall receive.

The board’s statistics show a decline in referrals for vocational rehabilitation services between 1994 and 1997; a similar decline in referrals was also reported between 1991 and 1994. Statistics on referrals to the Vocational Rehabilitation Services Department are not always consistent from source to source, and may include some double counting.

It appears that the board offers a range of services in keeping with those offered by other rehabilitation providers. Based on commission research, the Workers’ Compensation Board appears to be one of the more generous boards, in terms of providing funding for business startups and in its breadth of counseling.

Based on the guiding principle that “Different approaches be used in response to the unique needs of each individual,” the level of expenditure on services is determined on a case-by-case basis by the vocational rehabilitation consultants. The decision depends on a variety of factors such as the age and motivation of the injured worker and the likelihood of job opportunities at the end of services. However, vocational rehabilitation consultants are controlled to some extent in the level of services they provide by limits contained in financial spending authorities.
The *Manual* and *Handbook* seem to clearly lay out goals, policy, purpose, process and procedure. Despite this clarity, the discretionary power granted by the Act means that a lot is left to the vocational rehabilitation consultants’ common sense; consequently, practice is not always consistent. This creates a potential for actual or perceived unfairness in providing services which cannot be verified or denied due to a lack of data. As discussed elsewhere in the commission’s report, quality assurance mechanisms within the board, in general, and within the Compensation Services Division specifically, need to be enhanced. The Vocational Rehabilitation Services Department has implemented a number of changes in recent years intended to enhance the quality of service delivery in this area, but recognizes that there is more that needs to be done. A lack of information for injured workers (brochures or handouts) on vocational rehabilitation services may strengthen claimant concerns that services are not being provided fairly. There is a sense that those who know the system get the services.

The CEU, in its submission to the commission, states that while some improvement has occurred, there remains extensive inconsistency and confusion in the application of policies and procedures, as well as a lack of clear direction from management. The CEU spoke of discretion and inconsistency around a variety of vocational rehabilitation services, including Code R, business startups, and the appropriate length of time for which job search benefits should be paid.

It is essential that clear directives regarding entitlement to job search and parameters for job search be developed to ensure an equitable and logical application of benefits to injured workers.

Some questions that continue to perplex people include:

- Can a worker be forced to relocate for employment purposes?
- How much job search allowance should an individual receive? (The department uses Statistics Canada guidelines for job search allowance; however, these too are open to interpretation.)
- Should vocational rehabilitation consultants follow up with clients after they have returned to work? Is follow-up part of “quality rehabilitation?”

In addition, vocational rehabilitation services are generally provided to claimants likely to have a permanent impairment.

While this is generally considered to be the group most in need, it may exclude many persons with Activity-related Soft Tissue Disorders (ASTDs) who may be eligible for preventive, but not for other vocational rehabilitation services. Early vocational rehabilitation intervention with some of these claimants might have long-term benefits. In these cases, extensive intervention may not be necessary; instead, limited interventions, to modify work processes or work stations to reduce the likelihood of reinjury, could be offered.
The 1997, *Vocational Rehabilitation: Policy and Practice at the WCB of BC*, reported that:

> There is no question that new management structure of the Vocational Rehabilitation Department has made considerable progress in addressing the concerns identified in the 1995 administrative inventory. The most significant accomplishments have been in the areas of establishing clearer guidelines, expectations and standards of practice for the Vocational Rehabilitation Consultants, and in providing an improved level of clinical supervision within the Department.

In the board’s response to the review, it stated that achieving consistency must be a priority for the department. It stated that a number of initiatives would be undertaken to improve the consistency of vocational rehabilitation interventions, including:

- coaching efforts to improve the quality of documentation for each vocational rehabilitation case;
- refinement of “Performance and Client Service Expectations” document;
- continuation of individual and team case conferencing; and
- development of additional guidelines and standards of practice.

**Re-Training**

The appropriate retraining/pension mix in any given case is a matter of board judgment, based on a multitude of factors which include the worker’s motivation, choice, aptitudes, as well as an assessment of the realistic chance of success and job opportunities, current and future.

There may be cases where workers are interested in training beyond their pre-injury capacity. This cost should not be borne by industry. Once the pre-injury capacity has been fully restored (or partially restored, with a pension making up the difference), the injured worker is, economically speaking, no longer in any different position than his non-injured co-worker. Equity demands that the obligation of industry ends there. If a worker wants to be trained beyond pre-injury capacity, the worker, like any other student, should pay for that training and have access to applicable public funding.

If a worker wants to train to a level higher than pre-injury earnings—provided the board is convinced this is a realistic option—the board could pay for it if the training didn’t cost excessively more than restoring earning capacity to pre-accident levels. Clearly this is an area requiring the exercise of very broad discretion and flexibility in approach.
Therefore, the commission recommends that:

34. Section 16 of the *Workers Compensation Act* be amended to:

a) make clear that the primary objective of vocational rehabilitation is to restore the earning capacity of the worker, as far as reasonably possible; and

b) provide that, in determining whether vocational retraining is to be provided, and the nature and extent of such retraining, the board shall consider the following factors:

i) the extent to which earning capacity will be maximized;

ii) the level of resources required to complete the retraining;

iii) the expected duration of the retraining program;

iv) the preferences of the worker;

v) the realistic probabilities of the worker successfully completing the program;

vi) the long-term outlook or demand for employment in the identified area; vii) the motivation of the worker; and

viii) such other matters as the board may deem relevant.

**Employability Assessments**

Vocational rehabilitation consultants are often called on to conduct “employability assessments (EA)” which are used by Disability Awards to help determine the workers’ eligibility for a loss-of-earnings (LOE) award. As described in the 1995 Administrative Inventory, *The Workers’ Compensation System of British Columbia: Still in Transition*:

In conducting this assessment, the consultant is required to identify occupations that appear suitable and reasonably available to the worker over the long term future (short term for Section 30). In identifying the suitability of occupations and resultant wage earning capacity, the consultant is required to take into consideration the limitations imposed by the residual compensable disabilities,
and the potential vocational rehabilitation measures or interventions that may be of assistance to the individual worker in pursuit of these reasonably available occupations.

This task requires a high degree of skill to identify occupations that are consistent with present physical limitations of the individual, and the ability to actually predict the potential earning capacity of the job if training and other theoretical interventions were applied. It is the predictive aspects of this process that appear problematic for the consultant in projecting the worker’s earning capacity. In cases of temporary partial disability, the consultant identifies suitable employment opportunities (as opposed to occupations), which are available immediately or within the period under review (2 weeks, one month). In making this determination the consultant needs to be reasonably certain that workers would have these opportunities open to them, should they wish to apply.

Vocational rehabilitation consultants interviewed by commission researchers noted that they do not have all the tools they need to do this task. For example, they lack adequate demographic and job-related data (i.e., wage rates, hiring trends, availability of work, skills and training required, physical requirements, etc.)

According to the CEU:

until recently there were no provisions to provide standardized labour market information to all VRC’s. Each service delivery area and area office had available to them the labour market information that the VRC’s and support staff for that unit had managed to gather and organize.

VRS management has recently announced a pilot project whereby labour market information will be gathered and pooled as a database that all VRC’s can contribute to and access. The database will be valuable in preparing relevant EAs, and in obtaining information for retraining, and re-employment plans. This should reduce the duplication of research that is currently the practice. It should also help eliminate the hastily prepared EA that deems a worker capable of working as a “security guard” or “gas station attendant.”

Deeming

Deeming has been recognized as a controversial practice for many years. As early as 1983 the board’s document Compensation for Permanent Disability stated that deeming “is one of the most controversial areas involved in the loss-of-earnings concept.”
The practice involves the vocational rehabilitation consultant making the judgment that the worker is capable of performing a particular job or occupation, and that the job is reasonably available to the worker. Deeming decisions affect eligibility for continued compensation for economic loss, and the amount of compensation that is provided, based on presumed options and expected future states.

In a presentation to the commission, the board presented four conditions under which deeming could occur: (Decision #160, as reported in Workers’ Compensation Reporter, Volume 2, p. 218):

- the worker does not have a job but is considered employable;
- the worker has a job but it does not maximize long-term earnings;
- the worker, for personal reasons, decides to withdraw from the labour force; and
- the worker fails to cooperate with the vocational rehabilitation consultant.

Deeming assumes that some workers would choose to work less or take a lower paying job if they had the option of having their economic loss covered by workers’ compensation. If this is true, then the primary advantage of deeming is that compensation does not serve as a disincentive to return-to-work for those capable of working. The primary disadvantage is that workers who would choose to return to work but are unable to do so, may not receive compensation to cover their economic loss. In some cases these reasons may have to do with a mix of choice and opportunity.

Guidelines for deeming in the Rehabilitation Services and Claims Manual (#40.12 and #89.11) are that the job be “suitable and reasonably available.” There have been concerns expressed about how the board defines “suitable” and “reasonably available.”

Deeming is a common practice in Canada. The board’s briefing paper, Permanent Disability Pensions, states that “All other provinces that grant pensions for earnings loss have some kind of process for deeming earnings where the worker is found not to be earning as much as he could.”

A 1994 article entitled Compensation Systems for Injury and Disease: The Policy Choices also discusses the issue of deeming and provides a number of examples where complaints about deeming can occur:

- female claimants have been told they could become telephone canvassers, and are deemed if they decline;
- male claimants are told they could be employed as night clerks in a motel and are deemed if they object that this would disrupt family life; and
• deeming of workers to be capable of earning income in jobs that are not available due to such things as high unemployment rate or the mix of industries locally.

The board’s briefing paper on *Vocational Rehabilitation and Re-Employment Issues* states that questions about the appropriate use and credibility of employability assessments continue, and that the outcomes of these assessments are frequently the subject of appeals. It notes that criticisms of the process relate to the board:

• deeming workers to be capable of engaging in work for which they are not qualified without first being given appropriate training;

• deeming workers to be capable of obtaining employment at rates of pay that are unrealistic for the jobs in question; and

• deeming workers to be capable of obtaining work in fields of employment in which job opportunities do not exist.

The board’s briefing paper on *Permanent Disability Pensions*, notes that, with respect to deeming:

• workers contend that the board uses jobs that are not suitable or available in order to avoid costs; and

• employers contend that the board shows too much consideration for workers’ preferences.

The 1997 review, *Vocational Rehabilitation: Policy and Practice at the WCB of BC* states that critics of the board’s performance believed that deeming was becoming both more frequent and more unrealistic than it had been in the past. The review also reports that the Workers’ Adviser’s Office and other worker advocates were concerned that there had been a significant increase in the incidence of deeming since 1994. In January 1997, a letter from the director of the Workers’ Advisers to the director of Disability Awards suggested that deeming had increased by 44%, with a projected reduction in loss-of-earnings awards paid to permanently disabled workers of approximately $20 million per year.

Employers argue that deeming is necessary in a system where loss-of-earnings awards are granted, and that they are a last resort when the worker refuses to cooperate or get involved with the system. The board has also stated explicitly, (March 5, 1998 presentation to the commission), that deeming was to be used as a “last resort,” although statistics provided by the board on the use of deeming suggest otherwise.

The commission notes that in order for the board to determine which method of determining loss-of-earnings capacity is “more equitable,” some form of deeming must occur in all instances. The frequency and equity of that process is of some
concern to the commission. According to the board, from 1993 through 1997, between 554 and 700 LOEs were granted per year, and between 39% and 59% of these awards were not based upon an actual post-injury wage. There appears to be a steady increase from 1993 to 1996 (41.1%, 41.6%, 55.6%, 59.4%), with a drop in 1997 (39%). This suggests that there has indeed been an increase in these types of deeming decisions.

It should be noted, that these statistics on deeming apply only to LOE awards; deeming decisions can be made in other situations. For example, a worker who has been on short-term disability benefits, and is not back to work (or is back at a reduced income), may have benefits terminated if the board determines that he or she could be employed. According to interviewees, appeals of deeming decisions have been launched when:

- a worker is not back to work (or is back at a reduced income) but a decision is made that the worker is not eligible for a pension, because it has been deemed that there is no permanent disability and will be no loss of earnings;
- a worker is not back to work (or is back at a reduced income) but is deemed to not have a loss of earnings, and thus is only eligible for a functional pension award;
- a worker is not back to work (or is back at a reduced income) and is deemed able to earn at a particular rate in order to establish the size of the loss-of-earnings pension; and
- a worker whose pension is reviewed after two years is subsequently deemed to not have a loss of earnings.

The deeming statistics provided by the board apply only to workers in the third category. A submission to the commission on behalf of injured workers argued that:

when deemed employability rather than a real return to work becomes the standard for assessing the loss-of-earnings pension and the need for rehabilitation, the only winners are the board and the employer. The worker loses a substantial part of the pre-injury earnings without compensation.

The CEU, in its submission to the commission, stated that:

Current loss of earnings policy uses two key factors in considering loss of earnings: (1) jobs must be “suitable” and “reasonably available” to the worker, and (2) that job would “maximize” the worker’s earnings capacity in the long term.
The board can “deem” that certain jobs are “suitable” and would be “reasonably available.” The “deeming” process is extremely judgmental and open to numerous interpretations.

Rehabilitation and Compensation Services Divisions does not appear to have had in place an effective process for monitoring the extent to which workers deemed able to return to work, actually return to work, nor the extent to which workers, deemed capable of earning a particular income in the future, earn that income. In fact, Rehabilitation and Compensation Services Divisions was unable to provide any information on deeming decisions for short-term disability (STD) claimants, or on their return-to-work outcomes. While the division has a process to follow-up LOE claimants two years after awards have been established, it is only sporadically followed. Data provided to the commission shows that in 1993, 1994 and 1995, Proof of Earnings forms were sent out to about 60% of LOE recipients, but earnings information was received from only about 17%. Audits conducted by the board’s Internal Audit Department suggest that:

- when claimants do not respond to the request for information at this two-year review, the investigation may end there; and
- the earnings information provided by workers are not independently verified through T4s or other means (the division was unable to provide statistics on the number of claims investigated for fraud and the outcomes of investigations).

The commission is of the view that deeming is necessary in appropriate and prescribed circumstances. The commission also considers “suitable and reasonably available” and “in the long term” to be appropriate standards by which employability should be measured, given an injured worker’s duty to reasonably mitigate his loss.

Of course, there will be circumstances in which the decision not to return to work, or to return to a job that is less economically rewarding than the pre-injury job, is made on the basis of personal preference and not medical necessity. In these circumstances, which should be identified only after careful judgment and consideration, the board must have available tools to reach a compromise solution which achieves the objectives of the board and recognizes the worker’s right to personal choice. In these cases, closure will not result in a level of compensation that reflects the worker’s actual loss, but will result in a level of compensation that reflects the loss that would have remained had the worker maximized his/her earnings potential.

In interviews for the royal commission, it was argued that there should be more rigor and very strong guidelines around how these deeming decisions are to be made, as well as more information on how often and under what circumstances deeming is being used.
The board needs to examine how it might improve its guidelines around deeming, so that it becomes more of an objective process. Lessons may be learned from other jurisdictions within Canada where reviews of deeming processes have recently been conducted.

While the commission is of the view that deeming is a necessary prerogative of the board, it is important that deeming not occur until after vocational retraining and/or other appropriate interventions have been completed and assessed. Clarifying what the board considers to be a “last resort” would also be helpful.

The board has an obligation to assist workers to overcome barriers in returning to work. This obligation would be enhanced if employability was determined with respect to a range of possible occupations, rather than a small number of specific jobs. This would allow more flexibility in retraining, job search assistance, and other services. It might also address the allegation that certain jobs (i.e., parking lot or gas station attendant) are used too frequently in the deeming process.

Therefore, the commission recommends that:

35. the Workers’ Compensation Board:
   a) ensure that the policy addressing post-injury earning employability emphasize the development of employable skills; and
   b) in determining post-injury earning capacity, take appropriate measures to ensure that deeming of unrealistic occupations does not occur and not be allowed as a substitute for appropriate vocational rehabilitation.

**Income Continuity**

The board applies a dual system to assess permanent partial disability awards, based on a projected loss of earnings and a loss of function. To project loss of earnings, an employability assessment by a vocational rehabilitation consultant is required. The employability assessments are then provided to Disability Awards, where a final decision on entitlement to a pension, and what the amount of that pension will be, is made. Vocational rehabilitation consultants have often used what is known as “Code R” payments to pay workers benefits when they are no longer eligible for other vocational rehabilitation benefits (such as job search allowance), until they are assessed for a pension. However, the use of Code R has been controversial, and the board has recently implemented changes in practice to address some of the concerns.
According to *Vocational Rehabilitation: Policy and Practice at the WCB of British Columbia* (1997), Code R payments were initiated in 1987 when the board decided to eliminate STD wage loss benefits once an injured worker’s condition had stabilized. Since employability assessments, and pension determinations themselves, are often difficult and time consuming, Code R benefits were introduced as a bridging benefit.

There was a great deal of concern expressed by some external stakeholders through the early to mid-1990s, when it was observed that the cost of Code R payments was increasing. A backlog of employability assessments, which presented a major challenge to the board, were responsible, in part, for this increase.

This is because Code R benefits were based on the STD rate; pensions are almost invariably lower than STD benefits. Thus, the longer the delay in completion of an employability assessment and rendering a pension entitlement decision, the longer Code R benefits were paid, resulting in an increase in “overpayment.” (Overpayment was seldom recovered by the board.)

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During 1995 and 1996, “a policy analyst, who became convinced that the routine practice of extending Code R benefits to clients awaiting pension determinations, regardless of VR status, was illegal,” initiated a debate on how to handle Code R payments. The result of this debate was a practice change: Code R benefits were set at the estimated permanent pension benefit. As described by the 1997 Vocational Rehabilitation review:

> the [VRC] gives immediate effect to his or her Employability Assessment by implementing a Code R benefit based on the hypothetical (deemed) earnings that have been assigned. It is this specific change which is the subject of labour’s outrage. Rather than continue weekly wage loss payments at the temporary disability benefit level, the Workers’ Compensation Board is moving immediately to lower weekly payments to the estimated pension level, unless the individual is participating in vocational rehabilitation activities.

The net effect of this practice change was dramatic; 1995 to 1996 saw a swing in Code R payments from $7.5m to minus $243,270 “Code R” Expenditures (1988-1997).
This swing of nearly $8 million in expenditures in one year’s time has certainly caught the attention of the stakeholder communities. ...WCB Management anticipates that Code R payments have now been reduced to approximately a break-even basis for the indefinite future.

The review notes that the actual impact on benefits was less than it appears, as the combination of accelerated employability assessments in 1996 and the lower Code R payments, meant more money was recovered from pension awards on old cases than was paid out on new cases.

In order to better assess the extent to which workers were obtaining bridging benefits versus having benefits terminated before receiving pensions, and the length of time workers without benefits wait for their first pension payment, the commission asked the board to provide information on:

- the average length of time from last STD payment to first pension (LTD) payment, including ranges and frequencies;
- the options that workers have, when the pay lag between STD and LTD payments is greater than one week (e.g., other benefits, Employment Insurance), along with rationale for using each option; and
- the number and percent of claimants who use each option.

The board’s response provided the difference in days from “effective” to “activation” date for Long-Term Disability (LTD) pensions, which reportedly was equivalent to the time from cessation of STD benefits to the first LTD payment. The response noted that some claimants who receive pensions (e.g., those with hearing loss claims) never receive STD benefits. For loss-of-earnings awards in 1997:

- 75 of 338 claimants (22%) had their LTD benefits activated within about one year (360 days) of their effective date;
- 136 (40%) had their benefits activated between one and two years (720 days) from their effective date; and
- 127 (38%) had their benefits activated more than two years after their effective date.

(Figures for functional pensions were 48% in one year, 29% within one to two years, and 23% in more than two years).

Interpretation of this information is limited by the way in which it was provided, and by the fact that the response was incomplete. The commission is unable to determine from this information what number of injured workers receive full, partial or no benefits between the effective and activation dates.
The absence of a clear mandate with respect to ensuring income continuity from the date of injury through to pension determination, coupled with procedural delays, places workers at risk in terms of benefit termination. The CEU has stated that the practice revision effectively meant that some workers could be left without benefits while they waited for the employability assessment. Furthermore, vocational rehabilitation consultants' benefit predictions, based on the assessment, may not match the eventual pension. A worker could go from full wage-loss payments (or vocational rehabilitation benefits) to nothing while awaiting an assessment, to a reduced Code R on the basis of the vocational rehabilitation consultant’s assessment, to a different amount once the pension is finally determined.

The CEU also stated that the income continuity procedure was being applied inconsistently.

In August 1998, the Workers’ Compensation Board amended the Rehabilitation Services and Claims policy #89.11 and added policies #89.12, and #89.13. These policies authorize the board to pay a rehabilitation allowance to workers who are not actively engaged in the rehabilitation process but are waiting for the assessment of their disability pension. Details concerning when the allowance will be granted are set out in the policy.

The policy continues to provide the board with discretion in terms of whether or not income continuity payments are made; however, it provides greater clarity in terms of when these benefits are to be paid and the rate at which they are to be paid. As was the case with the former policy #89.11, the benefits are to be considered for workers who are likely to receive either a significant permanent partial disability pension award based upon the permanent disability evaluation schedule, or a pension calculated on the worker’s potential loss of earnings under Section 23(3). The new policy #89.12 states that, effective September 1, 1996, continuity of income payments will be based on the same rate as the worker’s wage-loss benefit rate (as had been stated in former policy #89.11) and will continue at that level until the pension is awarded, unless the worker has retired, is experiencing non-compensable problems which preclude active participation in the rehabilitation process, or refuses to actively participate in the rehabilitation process. In these cases, the vocational rehabilitation consultant is to complete the employability assessment and adjust the income continuity rate to the rate which reflects the conclusions contained in the employability assessment.

The policy also states that, as part of the completion of the employability assessment and prior to adjusting the income continuity rate, the vocational rehabilitation consultant must investigate the worker’s circumstances and must consider the impact of the compensable disability on the worker’s decision to retire or not to participate in the rehabilitation process.
The new policy also addresses the problem faced by workers who are already receiving a pension while they are awaiting a pension review. Policy #89.13 states that continuity of income payments will be considered for those workers who are already receiving a pension, where the board is reviewing that pension, and where it is likely that the worker will receive either a significant increase in the existing pension or a pension calculated on the worker’s potential loss of earnings. The policy requires that there is evidence of a deterioration in the worker’s medical condition which is likely to be permanent, and that the worker is experiencing a reduction in income during the review period which is related to the reasons for the pension review.

Elsewhere in this report the commission discusses the calculation of income continuity benefits within the context of the vocational rehabilitation and pension determination process. In particular, the commission proposes to introduce the employability assessment as a standard practice in developing the vocational rehabilitation plan, with completion of the employability assessment immediately upon the worker’s medical plateau. This approach assumes that the employability assessment can be depended upon to accurately reflect, in the majority of cases, what the ultimate pension decision will be. With this approach, all workers awaiting pension determinations will receive income continuity benefits based on the employability assessment. In addition, workers who are actively participating in vocational rehabilitation will receive “participation benefits” which, together with the income continuity benefits, will be equivalent to their prior wage loss benefits. The differences between this proposed approach, and the board’s current policy, are discussed Volume Two, Adequacy of Benefits.

Income continuity will likely continue to be an issue for workers, in part because of a lack of clarity regarding entitlement across all phases of a worker’s claim, and because of the time lags that occur at various decision points, due to the complicated nature of the decisions, and to process/efficiency issues.

Regardless of these challenges, injured workers have a right to continuity of income. It is a fundamental aspect of the historic compromise that should not be subject to discretion. If short-term wage loss benefits are terminated at medical plateau, income continuity benefits must be provided at the total disability rate until fair and realistic alternative payments more closely tailored to the anticipated ultimate loss can be estimated, and such benefits should be paid until the loss of earnings award is determined. In the event that the final award is more than the estimated amounts, the difference should be made up; in the event that the final award is less than the estimated income continuity benefits which had been paid, the excess payments should not be recovered in the absence of fraud or misrepresentation.
The commission agrees that for workers awaiting pension determinations who have retired, are experiencing non-compensable problems which preclude active participation in the rehabilitation process, or refuse to actively participate in the rehabilitation process, the rate should be adjusted, as proposed by the board, to reflect the estimated pension entitlement as determined by the vocational rehabilitation consultant through the employability assessment. If a worker refuses to cooperate with the employability assessment or the vocational rehabilitation plan, wage loss benefits should be continued until the worker can be deemed a post-injury income.

Therefore, the commission recommends that:

36. the Workers Compensation Act be amended such that a worker entitled to a loss of earnings award be provided continuity of income from the conclusion of short-term wage loss benefits until commencement of the award at a rate estimated by the board.

Timeliness of Services

It is well established that workers who are disabled and away from work have a 50% chance of returning after a six-month absence; a 20% chance after a one-year absence, and only a 10% chance after two years’ absence. As the 1997 National Institute of Disability Management and Research report Strategies for Success states:

For a disabled worker, the chances of finding a new job after a long-term absence are often grim. Early intervention and graduated or transitional work options are made possible by disability management programs, maintaining the connection to the workplace and facilitating successful return to work.

“Timeliness and early coordination with medical and physical rehabilitation” is one of vocational rehabilitation’s seven principles. The importance of timeliness is stressed in virtually every related document reviewed by the commission’s researchers. At the same time, the division does not report on the timeliness of referrals to vocational rehabilitation services. The board is reportedly addressing this oversight.

In the board’s presentation to the commission in March 1998, it was noted that the primary benefit of the case management model for vocational rehabilitation is that it will promote earlier involvement and intervention by vocational rehabilitation
consultants. According to the board, where vocational rehabilitation consultants in the past tended to become involved in the claim at the time of physical plateau, they will now be involved in the initial case discussions and return to work planning which occurs within a few weeks of the date of injury. The vocational rehabilitation consultant is expected to provide expertise and support to the new case management team in developing and implementing return to work plans.

An evaluation of vocational rehabilitation for back-injured workers conducted by the board in 1994 found that referrals to the Vocational Rehabilitation Services Department were driven by medical plateaus and wage loss terminations. At least two-thirds of the back-injured workers whose files were reviewed as part of the evaluation were referred to vocational rehabilitation within a year of their injury occurring, the majority before their wage loss benefits ended. However, almost one-quarter were made after this time. Interviews conducted for the evaluations suggested that “most of the time referrals came too late” with some reportedly made “well past the ‘two years after injury’ mark.”

The 1995 Administrative Inventory observed that there appeared to be:

great variability experienced in the timing of the referral to the consultant and in the level of effort by the consultant to intervene quickly once the referral has been made. …Throughout the WCB, while there appears to be general agreement regarding the potential value of early intervention efforts by the consultant, there are also some serious barriers to this involvement that require attention. These include natural time delays in the claims adjudication process, situations where there are discrepancies between worker subjective complaints and medical evidence, caseload demands, and a growing trend…where consultants are spending more of their time working at their desks and less time with employers (in this case particularly the accident employer) and in the community.

Case management is expected to improve this situation, by involving all parties early in the claim.

**Third-Party Service Providers**

While most vocational rehabilitation services are delivered by internal staff, there are contracts with some external service providers (a preferred provider list currently has 147 providers on it). These third-party service providers are used for specialized services or resources at the discretion of vocational rehabilitation consultants: if a vocational rehabilitation consultant feels a situation warrants external involvement, then the vocational rehabilitation consultant discusses the need with the manager and, upon approval, makes the arrangements.
Information presented to the commission shows third-party provider expenditures by type of service for 1997 as follows:

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<tr>
<th>Service</th>
<th>Expenditure</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Functional Capacity Evals/Worksite Job Analysis</td>
<td>$609,768.66</td>
<td>47.6%</td>
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<tr>
<td>Job Placement Services</td>
<td>$372,778.74</td>
<td>29.1%</td>
</tr>
<tr>
<td>Vocational Testing</td>
<td>$108,887.26</td>
<td>8.5%</td>
</tr>
<tr>
<td>Job Finding Clubs</td>
<td>$103,763.15</td>
<td>8.1%</td>
</tr>
<tr>
<td>Training/Tutoring</td>
<td>$62,770.30</td>
<td>4.9%</td>
</tr>
<tr>
<td>Business Feasibility Studies</td>
<td>$61,489.28</td>
<td>4.8%</td>
</tr>
<tr>
<td>Specialized Services</td>
<td>$33,306.69</td>
<td>2.6%</td>
</tr>
<tr>
<td>Rehab Planning (out of Prov)</td>
<td>$6,405.13</td>
<td>0.5%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>$14,091.29</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>$1,383,260.50</strong></td>
<td><strong>107.2%</strong></td>
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The use of third-party providers has required that the board develop performance and accountability measures for contractors.

In its March 1998 presentation to the commission, the board discussed the development of preferred providers lists for job finding clubs and other vocational rehabilitation services, such as feasibility studies. For the job finding clubs, all preferred providers reportedly deliver a model accepted as the standard in the vocational rehabilitation profession, and will be expected to submit data on a regular basis summarizing outcomes. The outcomes identified by the board include: durable return to work (defined as suitable work sustained for three months following the conclusion of the program) and client satisfaction. It was also noted that some services in the community are available at no cost to the board or to the worker.

The commission's research determined that, at least at the time of the study, the department had not had sufficient resources to conduct an extensive analysis of the use and quality of external providers or to safeguard service suppliers as an asset. One of the recently hired managers has been assigned responsibility for this area. The job includes reviewing 1997 statistics, cleaning up external provider work, putting a pro forma contract in place, and making the statement of services more outcome focused and less ad hoc. The intent is to include a three-month follow-up as part of the contract requirement. According to the department, the intent of this work is not to have more contracting out, but to clean up a process that has been going on for a long time.
Therefore, the commission recommends that:

37. the Workers’ Compensation Board monitor and evaluate the competence and quality of rehabilitation services provided by third-parties. This should include:
   a) performance standards that provide reliable and valid information on the quality of services provided;
   b) an obligation on third-parties to report on compliance with performance standards; and that
38. the Workers’ Compensation Board:
   a) use third-party information to maintain an up to date list of preferred third-party service providers; and
   b) provide workers access to the list of preferred third-party providers

When selecting third-party vocational rehabilitation service providers the commission expects that the board’s selection criteria would not be limited to the lowest bid, but would instead focus on the quality of service outcomes. Standards might be developed around, for example, the education and training required by providers, the range of services provided, internal quality assurance processes, costs of services provided, and outcomes (e.g., incidence of re-injury).

Workers should be provided with a list of preferred providers from which they may choose a provider of their choice, preferably within their community. Personal choice should be maintained and assured by the board so that, for example, if a particular treatment involves risk or is controversial, the worker has the option of selecting from a number of alternatives.

Workers should be provided with a list of preferred providers from which they may choose a provider of their choice, preferably within their community. Personal choice should be maintained and assured by the board so that, for example, if a particular treatment involves risk or is controversial, the worker has the option of selecting from a number of alternatives.
HUMAN RESOURCES AND STAFF TRAINING

Supervision

Currently, rehabilitation services are provided through a matrix form of administration, in which some staff receive administrative supervision from one source, and their functional (professional) guidance from another. It is not clear to the commission if the matrix is complete or whether it relates only to parts of these services. Some minor confusion regarding lines of authority was apparent during commission interviews with board staff. The board reports that in five area offices, six SDLs and all specialized areas, the first line manager is a dedicated vocational rehabilitation manager, while in six area offices, the first level of clinical supervision is provided by a manager with “blended” responsibilities.

Currently there is no job description for the director of vocational rehabilitation or a separate job description for senior managers who function under the same job description as client service managers. (The department has stated that it plans to create a separate job description for senior managers.) The job description for vocational rehabilitation consultants was revised June 30, 1997 and, apart from the fact that it does not specifically mention preventative rehabilitation, it appears to cover all aspects of the position.

The lack of job descriptions for the director and senior managers is disconcerting. Operating within a complex matrix poses enough problems; the lack of job descriptions adds to them.

The absence of technical support and clinical supervision for vocational rehabilitation consultants in the early to mid-1990’s, turnover at the director level, and extended vacancies in the senior level manager positions, have also been identified as factors that have affected the operation of the department.

Training

The Administrative Inventories are typically critical of the level of professional and staff development offered by the board and suggest there is a need for the board to continually enhance the skills and accountabilities of its front-line staff, including vocational rehabilitation consultants. The inventories conclude that the Workers’ Compensation Board will be able to respond to client needs and the new demands of the changing world of work only if staff have the appropriate technical, managerial and personal skills. Once staff have been trained in the goals and objectives of the system, they must be allowed to get the job done, with clear performance expectations and competent supervision.
Vocational rehabilitation consultants receive a minimum of four days per year for professional orientation. A professional development workshop is arranged for that time with guest speakers on a variety of subjects relating to vocational rehabilitation. Vocational rehabilitation consultants are encouraged to upgrade skills and gain professional certification and may receive financial support to complete the University of Calgary’s Masters in Rehabilitation program. In return, those enrolled are expected to work within the board for a specific time; should they cease to be a board employee before that time, they will have to repay some of the financial support, based on a sliding scale.

Vocational rehabilitation staff interviewed for the commission report that the time allowed for training has decreased. The vocational rehabilitation consultant training material developed two years ago envisaged a six-month development period. Now, according to the vocational rehabilitation consultants, vocational rehabilitation staff have a one-week orientation. There was some disagreement about the extent to which mentoring is provided for new vocational rehabilitation consultants.

Vocational rehabilitation consultants have broad discretion under the legislation and policy to determine what services are required and who will receive them. They have a critical responsibility to work with some of the most seriously-injured workers and to help re-establish their productive participation in the workforce. Vocational rehabilitation consultants require a multitude of skills, drawn from the social sciences, business and medical fields, to provide the necessary support while, at the same time developing realistic re-employment plans with their clients. Vocational rehabilitation consultants must be highly-trained professionals in order to ensure the discretion with which they are provided is exercised fairly, responsibly and consistently.

The Work Environment

The Vocational Rehabilitation Services Department has arrived at its current position after a great deal of unsettling changes. The low point appears to have come when the department was disbanded in 1994/95, which left vocational rehabilitation consultants without a professional focus. Also, there have been eight directors during the last 10 years.

Staff morale appears to have improved since 1995. Over a four-to-five-year period, from the late 1980s to early 1990s there was a turnover of more than 100 vocational rehabilitation consultants. However, staff turnover appears to have dropped significantly. By comparison, in the last year, there have been only four new hirings for permanent positions.
The commission’s research identified significant tensions between vocational rehabilitation staff, management, and the division’s senior executive. This was manifested in a lack of trust and security, and anxiety expressed in interviews; ultimately this will affect productivity. Board employees interviewed noted that many of the items raised during the commission hearings and through interviews have been raised by them frequently, in some cases over as many as 15 years. This has led to a view among some staff that management does not listen, preferring to implement huge initiatives, rather than make necessary, but relatively minor, amendments to existing practices. A frequent comment during interviews was “We work in spite of, not because of, management.”

Staff and some management also dislike recent changes in the physical work environment. Removing all the offices in the Richmond headquarters and replacing them with open cubicles was meant to foster a team approach to service delivery. According to many interviewees though, it has had the opposite effect, primarily because of increased noise levels and lack of privacy. The change is seen by many as part of a dehumanizing process.

For professional employees, the lack of privacy is an ethical issue that prohibits them dealing with clients in the manner in which they have been trained. One vocational rehabilitation consultant noted that staff in Burnaby SDL have been provided with earplugs because of the high noise level.

Staff are also concerned with safety, particularly with being at risk from clients whose benefits have been denied or terminated. In the last three years, there have been two serious physical assaults on vocational rehabilitation consultants, one in the office of a third-party job finding club, and one at a ferry terminal. A third vocational rehabilitation consultant received threats from a client, and the case went to court.

The board is sensitive to, and concerned about, personal safety. There are internal safety staff and the board provides ongoing training for staff on how to deal with hostile clients. Vocational rehabilitation consultants are provided with cell phones when on the road; home visits have decreased, largely because of the risk to staff.

**Board Initiatives**

While case management is viewed positively by many staff, there have been some concerns expressed about staffing issues. For example, some observed that:

• the full scope of the case manager’s job has not yet been achieved; especially with respect to Disability Awards and vocational rehabilitation functions;
• there are still some unresolved aspects in the relationship between the vocational rehabilitation consultant and case manager; and

• better solutions are needed to address the shortage of staff to fill vacancies when case managers are on holidays.

Under case management, claims adjudicators are rolling over into case manager positions, whereas vocational rehabilitation consultants will have to compete for the positions. Case managers may handle Phases I and II of vocational rehabilitation work, although the extent to which they will have the necessary skills or experience for this role is not clear. In contrast, the knowledge, skills and abilities set of vocational rehabilitation consultants is not considered adequate for the case manager position. Some vocational rehabilitation consultants see this as diminishing their role and professionalism.

PERFORMANCE MEASURES AND ACCOUNTABILITY

Key Performance Indicators

The primary measures currently used in the Rehabilitation and Compensation Services Divisions for vocational rehabilitation include: (1) return to work: the number and percentage of injured workers who have returned to work; and (2) closures: the number of clients released from the programs. The key performance indicators are:

• improve the safe return to work rate for workers with permanent disabilities by 10% by 2000; and

• improve the time from disablement to safe RTW by 20% by 2000.

According to the board, the first indicator is “based on the number of closures resulting in a RTW outcome divided by the total number of vocational rehabilitation closures for the given period.” The second indicator is “currently measured using retrospective duration, which reports the average number of wage loss days paid on a claim from first payment to first closure of the claim.”

As discussed earlier, the commission is unable to identify the base against which the improvement will be calculated. At the most fundamental level, the board has not defined the term “safe return to work.” There also appear to be no timeliness measures for vocation rehabilitation. There are no measures for outcomes other than return to work. For example, the department does not provide information in its business plan and similar documents on quality of life outcomes.

The Case Management Business Case Financial Summary identifies the key performance indicators that will be collected once this case management model is implemented. Those relating to vocational rehabilitation include:
• overall satisfaction level with complex case management;
• vocational rehabilitation referrals reduced by 5% in 1998, 10% in 1999, 10% in 2000, 10% in 2001, 10% in 2002; and
• safe and durable return to work for workers with permanent disabilities increased by 0% in 1998, 5% in 1999, 8% in 2000, 10% in 2001, 10% in 2002.

Once again, the bases against which these percentages are to be calculated are not stated. Neither is ‘durable return to work’ defined for the vocational rehabilitation context, although a definition has been used by the Rehabilitation Centre for several years.

The board’s key performance indicators for vocational rehabilitation provide little information on activities although there is some information on number of referrals, costs of various services, and numbers of employability assessments conducted.

The 1997 vocational rehabilitation review stated that:

The VRS Department has not maintained adequate statistics, on either inputs or outputs. Those that are available are generally not comparable over lengthy periods, either because of changes in the measures themselves, or changes in policy and/or practice. Historically, only financial information has been consistently available. In recent years, the Department has started to accumulate some outcome data that enable some comparisons across time, but these changes actually complicate the task at hand since they have introduced questions of comparability.

The 1994 Evaluation Study identified worker outcomes, other than return to work, that could result from providing vocational rehabilitation services. This included learning how to avoid re-injury: 65% of those interviewed stated they had been helped in this area a great deal.

Preventative rehabilitation is extremely important and, to the extent that it can assist workers in reducing the likelihood of re-injury, benefits everyone. It is an obvious area where the collaboration between Prevention Division and Rehabilitation and Compensation Services Divisions can and should be enhanced. The potential for this collaboration was clearly demonstrated to the commission when it viewed the Prince George pilot of the case management project, where a prevention field officer played an important role in the case meeting.

However, this hopeful level of collaboration was not demonstrated in the North Vancouver office where claims and rehabilitation staff told commission researchers that Prevention Division had decided not to participate on a regular basis on the case management team.
Client Satisfaction

Over the past several years, dissatisfaction with board activities has been documented many times through such vehicles as:

• the 1992 Canadian Facts survey of workers and employers;
• responses by stakeholder groups during the strategic planning process of 1995 and 1996;
• the Angus Reid survey of employers conducted in February 1997 prior to the launch of the case management prototype;
• the 1997 and 1998 monthly Angus Reid surveys of C, Z, B and Y claimants; and
• submissions to the commission.

There was also an Angus Reid survey of employers and workers conducted in late 1996 specific to vocational rehabilitation services.

These surveys and the documents referenced above collectively show a polarization in satisfaction levels: some workers and employers are very pleased with the way the board operates and the service they receive; others have a litany of complaints. To a large extent, those with shorter claims and less contact with the board are more satisfied; those with longer, more complex claims are less satisfied. Recent survey results from Angus Reid show the Workers’ Compensation Board is perceived by the public to be one of the least well managed provincial organizations among those surveyed.

Employers are dissatisfied with claims administration, which they feel is too slow; they want more involvement and would prefer more individualized attention and communication from staff. They are specifically concerned about spiraling costs in vocational rehabilitation. The most commonly-noted concerns among workers include long administrative delays, multiple “hand-offs” among officer level staff, poor communications, and unclear processes and roles. Attending physicians and other service providers have also expressed a level of frustration with the current system.

At the board’s presentation to the commission in March 1998, the 1996 Angus Reid client survey, specific to vocational rehabilitation services at the board, was discussed. Reportedly, compared to client satisfaction scores obtained in other client surveys for the board, which were between 7.2 and 8.3, the vocational rehabilitation survey showed satisfaction ratings of 4.5. Respondents also stated that the vocational rehabilitation consultants needed to be more accessible, provide more emotional support, show more sensitivity, care and concern, provide workers with more information, and spend more time in the workplace instead of in the office.
The board’s *Evaluation Study* provided detailed information on satisfaction levels with vocational rehabilitation services in 1994. It included surveys of workers and employers, detailed analysis of their responses to open-ended questions, and an analysis of gaps in service quality.

The study confirms the polarization of views discussed above. It found that 22% of workers were very satisfied, 33% were somewhat satisfied, 17% were not very satisfied and 23% were not at all satisfied with the services they had received. While 55% felt they were treated fairly through the process, 42% either somewhat or strongly disagreed with this statement. This level of dissatisfaction may be higher than for the board as a whole, as it focused on back-injured workers.

More recently, the submissions to the commission itself reveal a level of dissatisfaction among current and past clients, as well as among employers and other stakeholder groups. Some of the issues raised here include:

- impersonal attitudes (treated as a number), rudeness;
- individual cases handled by too many vocational rehabilitation consultants (too much change); and
- individuals not receiving the services to which they think they are entitled (especially business startup and training).

The Angus Reid Group conducts the board’s Customer Satisfaction Survey Project. This project is an evaluation tool used by the board in its attempts to address the service challenge stated in the 1996 Strategic Plan, to raise client service satisfaction to 85% by 1998. Data on a series of indicators are collected and reported monthly for both the province and by office/SDL. While there is no measure relating directly to vocational rehabilitation, surveys addressed to C (complex) claims most likely involve vocational rehabilitation services. These surveys found that C claimants were less likely to be satisfied with services received (40%), and less likely to perceive the system as trustworthy, fair and efficient.

Case management may improve this situation. Angus Reid surveys based on the 49 claimants who, in the period May to July 1997, had their claims processed through case management in the Prince George prototype show increases in overall satisfaction and satisfaction with the business processes.

The board is well aware of the low levels of satisfaction among certain claimants and employers, as well as others, such as referring physicians. As stated above, the *1996 Strategic Plan* references the board’s duty to provide timely, professional, efficient service “in a sensitive, respectful and effective manner.” This ‘service challenge’ (along with the other challenges identified in the plan) has continued to drive the planning process at both the corporate and divisional level. The *1998*
Corporate Business Plan, for example, cites client service as the first Rehabilitation and Compensation Services Divisions strategy. Client satisfaction is also a major driver behind initiatives such as E-file.

At present, there is no indication of whether the board’s return to work rates are good, moderate or poor. There does not appear to be a national or international benchmark. It is difficult to compare the board’s figures with those of other jurisdictions or organizations because there are fundamental differences between organizations regarding such factors as referral criteria, duty to accommodate, and economic climate. It is difficult to compare the board’s own figures from year to year due to the lack of consistency in data collection and reporting methods. Furthermore, the board does not measure the extent to which returns to work through vocational rehabilitation are safe or durable.

Quality of Data

Overall, research conducted for the commission, as well as previous reviews of the system, have concluded that the area of performance measurement needs critical examination and attention. Reliance on faulty or insufficient measures can only hamper the work of the board and harm workers and employers.

The board’s Internal Audit 1997 Report on Significant Issues confirmed that:

Management information issues contributed to a significant number of problems identified in Internal Audit reports in 1996 and previous years. This results from data which in some cases are: not accurate, not captured in a timely fashion, not well-defined at the board, captured in multiple places or not consistent, captured in some but not all cases, or not captured at all.

The Rehabilitation Performance Management (RPM) system is the mechanism established by the department to record and report its activities. This system, which came into effect in October 1996, replaced the previous Vocational Rehabilitation Case Management System (VRCMS). It was intended as a temporary replacement of the VRCMS. The Department is currently working on a permanent system that will be part of E-file.

The commission’s research identified many concerns with respect to the department’s management information systems as well as a number of problems specific to the RPM, including inaccuracies in the information recorded. The inadequacies of the department’s management information system was also noted in the 1994 Evaluation Study, which identified problems in monitoring case standards, limited performance measures, and double-counting due to improperly-recorded, reopened claims. The Evaluation Study made recommendations.
regarding performance measurement, which for the most part still appear valid today. It recommended that the board revise its performance measures for vocational rehabilitation to include:

- a redefined measure of return to work;
- the frequency with which specific services are being provided;
- relevant outcomes for services in addition to return to work (e.g., client satisfaction); and
- costs associated with providing specific services.

It also recommended that the board:

- conduct closure interviews with a sample of workers who received vocational rehabilitation services;
- conduct follow-up interviews at designated time points to collect information on return to work rates and other service outcomes;
- conduct follow-up interviews with employers; and
- develop an information system which would enable vocational rehabilitation consultants to manage interventions, from referrals to closures, and reduce their documentation requirements.

The board has stated that, in response to these recommendations:

- performance expectations have been introduced for all vocational rehabilitation consultants;
- a formal client satisfaction survey was conducted in 1996 and a follow-up is planned for 1998;
- follow-up procedures will be introduced in 1998 to measure ‘durability’ of return to work outcomes; and
- E-file, once fully rolled out, will collect all vocational rehabilitation information.

Stakeholders concerns about the board’s vocational rehabilitation practices—and other practices elsewhere in the board—could probably be alleviated if the board provided evidence that the processes followed and the decisions made were within reasonable bounds, something the board is currently unable to do because the relevant information is often not being collected or, as noted, is sometimes inaccurate.

_Vocational Rehabilitation: Policy and Practice at the WCB of British Columbia_ (1997) makes a similar statement in a discussion of the recent drop in the Vocational Rehabilitation Services Department’s expenditures:
In light of the turnaround in financial performance, it is perhaps not surprising that questions would be raised about “changes in policy” that would explain the substantial cost differences. In a system as contentious as workers’ compensation, any significant change tends to be attributed to a change in the balance of power or influence of one side or the other. Labour sees any reduction in costs as a symbol of employer influence, and employer groups see any increase in benefits as revealing labour’s dominance of the system. Unfortunately, the WCB gets caught in the middle, and largely because of a lack of internal analytical capacity is not able to offer satisfactory explanations to the stakeholders on either side.

Therefore, the commission recommends that:

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<th>39. the Workers’ Compensation Board adopt clear, consistent and rational indicators of:</th>
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<td>a) the success of vocational rehabilitation; and</td>
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<td>b) internal performance.</td>
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### Costs of Vocational Rehabilitation Services

In recent years, employers have been concerned about the rising costs of vocational rehabilitation. Although the department does budget for vocational rehabilitation service-related expenses and benefits, actual expenditures are determined by individual vocational rehabilitation consultants and managers, based on the needs of individual injured workers. It is left to the discretion of staff to determine when “enough is enough.”

The board’s briefing paper on *Vocational Rehabilitation and Re-Employment Issues* notes that total expenditures for vocational rehabilitation showed a period of modest growth from 1986 to 1990, followed by a period of great acceleration from 1991 through 1994. Total expenditures for vocational rehabilitation, as presented in the 1995 Administrative Inventory, were: 1986: $4,615,547; 1990: $12,855,514; 1991: $20,352,282; 1994: $68,606,888. These figures showed an annual rate of increase of 50% between 1991 and 1994, a period when, according to the briefing paper, new referrals to vocational rehabilitation decreased from 11,700 to 8,700.
Increases in all categories were evident over the period of 1986 to 1994, but particularly in Code E Job Search ($727,400 to $23,538,234), Code G Formal Training ($819,481 to $10,981,899), and Code R Income Continuity ($1,523,310 in 1987 to $8,486,029 in 1994). The “miscellaneous” code, which included a variety of costs as well as business start-ups, showed increases from $387,216 in 1986 to $13,484,287 in 1994.

Business plans show that costs began to decline in 1995 ($64 million). At the board’s presentation to the royal commission in March 1998, expenditures for 1997 were said to be about $42 million. The significant reduction in Code R costs account for a large part of this drop, but there were also decreased expenditures in other categories. At the presentation, it was also reported that the board spent more per referral in 1997 ($6,289) than was spent in 1993 ($5,338).

The division aggregates benefit payments under specific codes. However, the aggregation is slightly different than that presented in the 1996 Business Plan, and there are discrepancies between the actual totals for 1994 and 1995, as reported in the 1996 Business Plan and those reported in the 1997 Business Plan (the 1996 document includes codes not included in the 1997 document). The board presented yet another aggregation to the commission in March 1988. This method of presentation makes it impossible to track payments over time by individual codes.

A comparison of actual total benefits paid shows that over the last three years, expenditures have been lower than budgets, and in the case of 1996, significantly lower. The business plans include brief narratives on the differences between actual and budgeted expenditures. For example, the 1997 Business Plan notes:

Vocational Rehabilitation payments [for 1996] were lower than 1995 mainly as a result of the 15% decline in referrals to VRCs. Decreases mainly occurred in payments for job search allowances, business start-ups, services of third party providers and income continuity. The reduction in income continuity resulted primarily from an emphasis on completing Return-To-Work plans before Code R benefits are utilized and refunds from abnormally high LTD first payments.

The department tracks total expenditures against referrals, returns to work, and employability assessments completed. There does not, however, appear to be any analysis of total benefit payments to those for whom a return to work was an appropriate outcome, relative to those who actually return to work.

The division budgets for administration expenses. However, expenses related to the Vocational Rehabilitation Services Department are not separated from other claims in the business plans; therefore, it is not possible from these public
documents to determine department salary costs and expenses. It is also not possible to identify Departmental staffing levels. This information is tracked by the board but is not incorporated into its business plans.

Similarly, departmental systems now allow new claims, referrals, return to work outcomes (return to work, non-return to work, claims in progress), and employability assessments (referred, completed, in progress) to be tracked by SDL. Theoretically, these figures can then be compared with the number of vocational rehabilitation consultants in each SDL to arrive at some form of productivity ratio by SDL. However, the commission’s analysis of this data (period ending December 1997) showed that while almost all SDLs reported this information, there were some gaps. Service Delivery Regions East and West also appear to report differently from each other. Thus, comparison between SDLs is hindered.

The research team has identified the following audits conducted by the board’s Internal Audit Department that relate directly to vocational rehabilitation program expenditures.

- Code R audit—final report, dated May 29, 1992;
- Code R audit—follow-up audit, dated July 7, 1995;
- Vocational Rehabilitation Committee audit—final report, dated January 6, 1995;
- Vocational Rehabilitation Committee—follow-up audit, dated December 18, 1995; and
- Vocational rehabilitation third party service providers review, dated July 7, 1995.

Among the issues identified in the audits were unrecovered costs, inconsistencies in coding of payments, and difficulties tracking expenditures. For the most part, audit recommendations appear to have been acted upon by management.

Confirming the actual number of staff has proved generally difficult. In part, this is due to the matrix organization within the board. It is not, for example, simply a matter of counting names on organization charts: the same name may occur on different charts, because the position reports to one section or department for administrative purposes and to another for clinical/professional purposes, and more than once on the same chart, depending on the way responsibilities are distributed.

Rehabilitation and Compensation Services Divisions business plans estimate resources for the department as a whole. According to the plans, staffing levels have remained fairly constant in recent years, while the number of accepted referrals has declined.
The 1997 Administrative Inventory noted significant reductions in vocational rehabilitation expenditures. According to the report, some critics assert that these decreases demonstrate reduced attention to the legitimate needs of injured workers and are resulting in “walking wounded.” Critics are also concerned that in the last few years the number of persons approved for rehabilitation, and the length of services received, has decreased, forcing some workers to return to work too soon.

Cost-Effectiveness

There is insufficient evidence to determine whether the department is achieving its objectives in a cost-effective way:

- The board does not currently identify all inputs in such a way that they can be assigned by department.
- There are problems with the accuracy of outputs/results.
- The relationship between inputs and outputs has not been analyzed.

This is not a new problem. The 1994 Evaluation Study concluded that it was not possible to conduct the cost-effectiveness analysis outlined in the evaluation terms of reference because of a lack of data. The 1996 Administrative Inventory expressed concerns about ‘exploding’ costs that were increasing at an ‘alarming’ rate, noting increases in administrative costs were not matched by corresponding increases in productivity nor in outcomes. It called for more explanation and analysis into why this was occurring.

The 1997 Auditor General’s accountability review stated that administration and cost-effectiveness should be better measured and reported upon.

The report to the commission entitled Rehabilitation and Re-Employment Matters presents a list of the kinds of data required to determine cost-effectiveness of vocational rehabilitation services for return to work and pension related activities. Some of this information is currently collected by the board. A major limitation is the board’s current inability to distinguish between new referrals and re-openings, which results in the potential for multiple returns to work being reported for one claimant on one claim.

Staff have confirmed that the board is not in a position to determine its cost-effectiveness: they have an intrinsic belief that the services they provide are cost-effective, but such analysis has not been conducted. The board has also confirmed this. The 1998 Corporate Business Plan notes that: “In order to properly address administration cost-effectiveness, the board needs to examine its costs in unit of production terms and relate that to the performance criteria.”
Monitoring Quality

The department has undertaken a number of initiatives to achieve consistency in implementing policy in vocational rehabilitation. These include:

- improving the quality of documentation for each vocational rehabilitation case through standardized formats for key documents such as Initial Vocational Assessments, Employability Assessments, and Recommendations for Expenditure;
- refining the *Performance and Client Service Expectations* document;
- continuing individual and team case conferencing, including weekly team and frequent individual case conferencing; and
- developing additional guidelines and standards of practice.

Performance Standards for Staff

Individual performance expectations or standards were introduced in January 1997 in order to clarify and communicate standards between managers and vocational rehabilitation consultants and to ensure consistent levels of client service. The expectations are set out under the following headings:

- referral and acceptance of vocational rehabilitation files;
- initial vocational assessment;
- essential documentation;
- development of vocational rehabilitation plan;
- employability assessments;
- closure of files;
- payments; client service initiatives; and
- marketing initiatives.

Several of these expectations have timelines attached (e.g., initial review of file and referral memo: within five days of receipt of referral; all employability assessments to be completed within three months, with any exceptions to be addressed in consultation with Manager and documented on file; minimum of two weeks verbal and written notification to worker of any changes in benefit entitlement).

Analysis of Appeals

The commission tried to determine whether the percentage of appeals (successful and unsuccessful) relating to vocational rehabilitation services and employability assessments could provide information on clients’ perceptions of quality
of service. However, it is not possible to identify those that relate specifically to vocational rehabilitation, without conducting a manual search.

Copies of all of the important decisions on appeals with a vocational rehabilitation content are provided to the director of the Vocational Rehabilitation Services Department. These cover the gamut from plans that failed to go far enough, to inadequate job search allowance and denial of the purchase of a computer. Although the director reviews the appeal decisions she receives and shares the information with managers and staff, the department does not conduct any appeal-specific analysis (for example, determining if appeals are more common in certain SDL's or from specific desks). Managers are required to read all decisions.

**Accountability**

The commission is of the view that public accountability could be improved if there were more quantified targets and if the bases against which long-term objectives are to be measured were clarified.

In the Auditor General’s *Accountability Reporting Review*, which examined the board’s performance information, seven recommendations are offered regarding reporting for Rehabilitation and Compensation Services Divisions. All of these apply, to some extent, to rehabilitation:

- Explore the possibility of developing and reporting on pre- and post-injury incomes, in order to assess adequacy of compensation to injured workers.
- Assess and report on the success of the WCB rehabilitation network in restoring claimants to pre-injury physical and mental status.
- Provide results of a comprehensive return to work analysis which would include a break down of return-to-work results on various dimensions, durability, and information on reopenings.
- Report on the benefit entitlement/adjudication process in a way that would provide assurance on the quality of the adjudication process, including indicators of quality (e.g., allow/disallow rates, appeal rates), as well as factors that affect quality (e.g., corporate culture, policies, skill base of the staff handling claims).
- Report on the number of appeals and the outcome of these appeals for all the appellant bodies (i.e., not just Review Board appeals).
- Report on timeliness of client service, beyond simply the first short-term disability payment or long-term disability award.
- Provide more detailed timeliness information, beyond simple averages (possibly including ranges and frequency of distribution), to identify types of injuries or claims that pose a particular timeliness problem.
These are measures that the commission deems worthy of serious consideration. As discussed above, it is important that the board ensure that information collected in these and other areas is accurate, reliable and valid. Clear objectives need to be identified, including, but not limited to, return-to-work, and results tracked in terms of these objectives. Furthermore, services and outcomes should be tracked for individual clients (e.g., so that the board can identify the number of clients that receive each type of service, the range of services provided for clients with different backgrounds, and so that no double counting of referrals or return-to-work outcomes occur). Once reliable data are available, an analysis of costs relative to benefits (e.g., actual earnings and pension after vocational rehabilitation relative to projected earnings and pensions without vocational rehabilitation) should be conducted. Benefits may be considered both in financial and non-financial terms. Cost-benefit analyses should be carried out on an annual basis. In this way, the board will be in a better position to be able to justify its expenditures on vocational rehabilitation services, and to identify which programs and services are having the greatest impacts and are the most cost-effective.
Medical Services

MANDATE, MISSION, STRUCTURE AND STRATEGIES

Mandate

Section 21(1) of the Workers Compensation Act places healthcare under the direction, supervision and control of the board. This means that the board determines the healthcare provided to injured workers. In general, the board does this by holding the treating physician or practitioner responsible for treatment while acting as an advisor to ensure that the practitioner is aware of the treatment options. Subject to the Act, the worker is free to choose the physician or practitioner who will provide the treatment.

Section 56 of the Act sets out the duties of physicians and qualified practitioners who treat injured workers. These duties include providing reports, information, advice and assistance to injured workers and their dependants, with respect to compensation claims, without charge to the worker. Section 57 provides authority to require an injured worker to be examined or to reduce or suspend compensation if a worker declines essential treatment or performs acts that hamper recovery.

Mission

The Medical Services mission statement presented in the 1996 Orientation Manual for WCB Physicians reads:

- The well-being of the injured worker is our first concern.
- Continuing improvement in the quality of medical care and rehabilitation of injured workers is our challenge.
- Opinion which is objective, impartial, independent and in accordance with the Canadian Medical Association Code of Ethics is our commitment.

Objectives

The 1996 Compensation Services Division Business Plan established four corporate strategic directions for the Medical Services Department according to the structure laid out in the 1996 Strategic Plan.

- Customer Service:
  - to improve timeliness of medical opinions and examinations;
  - to continue decentralization of Activity-related Soft Tissue Disorder (ASTD)-related medical advice; and
- to improve access to external medical resources for pension and consultant exams.

- Financial Stability:
  - to work with other departments within Compensation Services Division to reduce the 1996 administrative budget for the Medical Services Department possible through implementation of a “recoverable” system and utilisation of local fee-for-service physicians for provision of advice to Disability Awards.

- Corporate Leadership:
  - to maintain a low level of grievances; and
  - to provide consistent, relevant and comprehensive feedback to all members of the department relating to key operational information, particularly with regard to timeliness.

- Community Confidence:
  - liaison with BCMA and UBC.


The board physicians’ role is complex, as they are challenged to provide care, education and other resources in a system that is part insurance company, part healthcare institution.

The environment within the Workers’ Compensation Board has been described as a place of many ‘turfs’ and administrative ‘silos’, where interaction does not occur, nor is it encouraged. Physicians are isolated from one another and from outside experts. Education, learning and knowledge receive minimal or token support. According to the commission’s research, the vision, purpose, goals and objectives are not clear to the physician staff of the Workers’ Compensation Board. This creates uncertainty as to the nature of their functions, hence implying that behaviour may also be inconsistent. The commission’s research on the Medical Services Department concluded that the central mandate of the Workers’ Compensation Board must be examined, and emphasis on the clinical care of the injured worker (directly and indirectly through other providers) must be reinforced.

Policies and Procedures

The Procedures Manual for Physicians includes descriptions of medical and client service procedures, such as clinical referrals, medical examinations procedures, medical negligence for malpractice, refusal of examination, and disability benefits.
Other standards and definitions are documented in a variety of sources. For example:

- The *Permanent Functional Impairment Outline* includes a discussion of: assessment of functional impairment, nervous system, vision, hearing, upper extremities, hand lower extremities, spine and pelvis, devaluation, enhancement, and age adaptability.

- The *Attending Physician’ Handbook* includes standardized assessment forms for patients with low back pain and for patients with cervical pain; clinical practice guidelines for low back pain, neck (cervical) pain, meniscal tears, carpal tunnel syndrome and epicondylitis; and the board’s expectations regarding reporting and confidential information.

- The *Clinical Practice Guidelines for Diagnosis & Treatment of Low Back Pain* discuss medical assessment, medical management, investigations, education and a variety of treatment modalities.

- The *Permanent Disability Evaluation Schedule* lists conditions an injured worker might experience with the percentage of total disability assigned. Included are: amputations, immobility, shortening, denervation, impairment of vision, impairment of hearing, compression fractures, and range of motion loss.

Interviewees had varying opinions and expressed frustration about the policies and procedures for medical services staff. Some believed the policies were restrictive; others believed they were inaccurate and inappropriate.

**Structure**

Prior to 1994, the Medical Services Department was a separate division which reported directly to the president and CEO. In 1994, the department was reorganized to become part of the Compensation Services Division. In the second quarter of 1996, Medical Services, Psychology and the Rehabilitation Centre were formed into the new Rehabilitation Division reporting to the Vice-Present, Rehabilitation and Compensation Services Divisions. The new structure was intended to complement common initiatives including early intervention, disability management, the continuum of care, clinical practice protocols and case management.

The 1998 budget shows a 31% reduction in “full-time equivalents” (FTEs) and a 51% reduction in net expenses over the 1997 budget. There is limited discussion about the department’s plans with respect to these reductions, although changes in activity are attributed to the new initiatives. For example, reductions in medical opinions and exams are noted in the business plans, and are attributed to the changing role of the medical advisor under case management. A reduction in Medical Services costs would be expected when replacing medical advisors with nurse advisors, a recent initiative referred to in the plans, and discussed in greater detail below.
Staffing and Functions

Under the current model, Medical Services staff are expected to provide sound, high-quality independent medical advice in a timely manner including: examining injured workers; providing advice to claims adjudicators and vocational rehabilitation consultants on medical matters related to claims; providing opinions to board staff; and conducting work site visits. Medical Services staff also supervise the physical rehabilitation of injured workers and are responsible for evaluating permanent functional impairment as part of the disability pension award process. Adjudication decisions based on medical advice can be reviewed by the Workers’ Compensation Review Board, the Appeal Division and medical review panels.

There are about 50 physicians currently working for the board in four categories:

- **Disability Awards Medical Advisors** (DAMAs) are a central group in Richmond who provide advice to the Disability Awards Department with regard to impairment, largely through the examination of injured workers. Area Office and Service Delivery Location medical advisors are undergoing training and providing this service; a pilot is underway to have external providers offer this service. Medical advisors are the largest group of physicians employed by the board.

- **SDL, AO and ODS Medical Advisors** work in a team environment with vocational rehabilitation consultants, case managers and psychologists (and nurse advisors). They provide advice and consultation on medical aspects of claims.

- **Specialists** such as orthopaedic surgeons, neurosurgeons and neurologists are brought in by the board to see patients for complex clinical issues. Specialists provide advice to medical advisors through file reviews and patient exams.

- **Rehabilitation Centre Physicians** work in a team environment providing medical services to the various Rehabilitation Centre programs. These physicians assess patients and provide advice to attending physicians and patients regarding diagnosis, treatment and/or anticipated outcomes in response to particular clinical needs. They also are asked to assess whether or not compensation should be continued.

The largest contingent of practitioners caring for injured workers are the roughly 3,000 “attending physicians,” who have variable amounts of interaction with the board. It is this group that actually provides the majority of care to injured workers.

The role of Medical Services staff is changing as the board moves toward implementing a case management model. While some of the functions listed above remain under the case management model, the medical advisor’s role, according to the board, “has been transformed to that of clinical care facilitators, working
together with the external medical community to ensure optimum care for their shared client. “This new role, now supported by nurse advisors, is expected to provide more of a focus on facilitating quality clinical service within the larger medical community and less on determining entitlement. The department plan is for medical advisors to have more direct contact with the case management team, offering assistance to the worker, the employer and the worker’s practitioner. According to the board, the goal is to have one medical advisor and one nurse advisor for each service delivery location (i.e., 17 of each), together with about 20 rehabilitation physicians and supporting programs. This will mean reducing the total number of physicians from 50 to 37 by the time the plan is completed.

The position of nurse advisor was introduced in 1997 (although approved in early February 1997, the position does not appear on the department’s March 1998 organizational chart). According to the board the motivation in replacing medical advisors with nurse advisors is not economic, but rather reflects the move to a model that is less forensic in nature and more holistic. The job description for the position notes that:

the Nurse Advisor reports administratively to a Compensation Services Manager and professionally to the Director, Medical Services for fulfillment of their responsibilities. The position works closely with the medical advisor, adjudication staff, vocational rehabilitation consultant, psychologist and other staff involved in case management. The position does not provide work direction to others.

There is some concern among the medical community regarding the nurse advisor position. The BCMA in its submission to the commission recommended that:

• The WCB provide full disclosure of the process used to develop the role and functions of the current nurse advisors employed at the WCB.
• The WCB initiate a review of the position of nurse advisors, and that the BCMA provide formal input into the review process.
• The WCB disclose the full job description and authority granted to Nurse Advisors.
• The BCMA be allowed to provide formal input into the process for establishing WCB Nurse Advisors.
• The final decision regarding patient care continues to rest with the attending physician.
• All recommendations of a Nurse Advisor regarding a patient are officially communicated to the attending physician.

Any outstanding concerns within the medical community should be addressed by the board and the BCMA.
Strategies

The Medical Services Department has undertaken a recent analysis of the business environment. External factors considered by the department include: a decrease in a new and ongoing level of claims, expedited service, the royal commission, electronic data, less major trauma, more ASTD- and stress-related claims, and increasing availability of external providers of medical advice. The internal factors identified were: departmental participation in the board’s transformational strategies such as E-file, case management, continuum of care and clinical practice guidelines, the need to prepare staff and management for business changes, and the increasing use of technology.

Case management, for example, offers opportunity for improvement in the way the clinical care and claims process are managed. The case manager oversees service delivery and guides progress to achieve safe and durable return to work. If a case presents unusual characteristics, the case manager may obtain advice from the case management team before proceeding. The team includes a medical advisor, vocational rehabilitation consultant, psychologists, and disability awards specialist (an occupational health nurse may also be involved). The case manager may contact the attending physician or refer the case to the medical advisor or other clinicians for consultation.

The medical advisor’s contact with community physicians is appropriate and advisable. It will improve the credibility among the community physicians of the board medical staff, and allow the board physicians to play a role that is proactive and supportive of clinical improvement for the worker.

However, in this new model, the medical advisor may be less involved with the patient than in the past. Although providing considerable contact with the attending physician, there is a probability that the board physician will see fewer patients and become mainly an educationally-oriented resource person. The risk associated with this is two-fold. If the case is clinically complex, as in some soft tissue or head injuries, the expertise of the board physician is critical to the actual ‘hands-on’ management of the case. Secondly, having less contact with patients, the clinical acumen of board physicians may decrease.

The concept of multidisciplinary care, inherent in the case management model, implies there is a tremendous dependency on teamwork and on individual members of the team.

It will be important for the board to assess carefully the implications of the changing role of the medical advisor. In particular, if there is reduced contact with workers under the new model, the impacts in terms of decision making and service effectiveness will need to be monitored and evaluated.
THE PROCESS OF MEDICAL CARE

Medical Staff and Interest Groups

Injured Workers

In submissions to the royal commission, many injured workers have a poor impression of board physicians, describing them as “anti-worker,” “biased in favour of the board” and not at “the leading edge of current medical practice.” As board physicians can have a pivotal role in the approval or rejection of a claim, a number of injured workers expressed frustration in cases where decisions were made without the medical staff actually seeing the patient.

The BC Federation of Labour’s submission to the commission notes:

A common complaint of workers is that Board medical advisors are insensitive and distrusting. They ask why they have to see a Board doctor with no particular specialty qualification when their specialist says they cannot return to work. Workers also ask why the opinions of Board medical advisors are so often at odds with their own doctors, preferred to treating physician’s, and often rejected on appeal. Our experience is that doctors themselves also ask these questions.

The submission recommends that more weight be given to the opinions of workers’ physicians, and that the governing body of the board, in consultation with the community, establish and publish standards of medical care and professionalism for board medical staff.

Community Physicians

Perhaps one of the most critical issues is the poor opinion of board physicians held by external physicians, an issue that may be embedded in history, in poor communication, or in a lack of clarity of the role of the board and its physicians.

Regardless of its origins, in the eyes of some external practitioners board physicians are guided more by insurance company policies than by the Hippocratic Oath. They see them as in the “back pocket of the WCB,” “changing decisions once the financial impact is known,” or providing a “biased opinion” against a claim rather than an unbiased presenting of facts. This impression is magnified when medical staff overrule the recommendations of outside family physicians or specialists, often based on what appears, to external practitioners, as either inadequate information or because of policy restrictions.
Board physicians told commission researchers that they feel their relationship with general practitioners is reasonable, that in reality there is usually very little debate about the underlying medical condition. There can, however, be problems of communication and occasional conflict.

**BC Medical Association (BCMA)**

The BCMA’s submission to the commission recommends the board ensure an effective framework for communicating policies/procedures to practicing physicians on a regular and timely basis. The submission also states that “the BCMA/WCB Liaison Committee is an appropriate vehicle for communication between the organizations,” providing an opportunity for input and feedback on policies that affect patients and physicians.

However, the BCMA is concerned that the WCB representatives are unable to influence change within the WCB. This sentiment has been acknowledged by WCB representatives. In order for this committee to be an effective change vehicle, the WCB must address issues which are identified at this committee.

**PREFERRED PROVIDERS AND WORKER CHOICE**

The board recently issued a practice directive which instructs staff regarding claims management and the continuum of care. Practice Directive #12 outlines steps staff are to take with respect to moving workers through the continuum of care, including contact with the worker’s attending physician. The CEU’s submission to the royal commission raises a concern regarding Practice Directive #12, suggesting it contains contradictions to Policy #78.10 on the direction, supervision and control of treatment.

According to published policy, the board only has jurisdiction to make suggestions, not to control treatment. It appears the administration is amending Policy 78.10 without actually overtly acknowledging that it is doing so.

This Practice Directive creates a “Continuum of Care” model based on preferred providers. One of the cornerstones of individual rights and freedoms in a democracy is the right to make choices in the selection of personal physicians and follow any treatment program outline by that physician. It appears that the “Continuum of Care” model ignores injured workers’ rights around choice in the area of treatment. This immediately sets up an increased adversarial relationship between the worker, the attending physician, and the Board.
One of the concerns the CEU has with the practice directive is that it seems to suggest the board will proceed with a referral to the continuum of care even if the attending physician is not in agreement, except under special circumstances which are also laid out in the practice directive.

The discussion above regarding preferred providers of vocational rehabilitation services is also relevant to medical services.

**Funding Issues**

With respect to funding of physicians, there appear to be three major components to assess: the salaries for the Workers' Compensation Board physicians, fee for service based upon Medical Services Plan (MSP) codes, and fee for service based upon the Workers' Compensation Board's unique codes. There is also some important information arising from the distribution of physician fees with respect to the Workers' Compensation Board's activities. Physician salaries will be discussed in the section on human resources. The other two funding issues have been the subject of some concern.

**MSP Fee For Service Type**

One component of fees for outside physicians is based upon MSP fees for recognized activities. For many years, this system has provided an extra four percent above the MSP rate, in accordance with the MSP/BCMA agreement. Recently another two percent was added to the contract to enhance the expectation of electronic billing and electronic report submission. The impact of these extra percentages on the average physician who does not work for the Workers’ Compensation Board is minimal and from an equity perspective, is not a major difference. However, perception is still a concern. Some have significant concerns that the extra funds for Workers’ Compensation Board work is the beginning of a two-tiered system (See Volume One, Governance and Accountability).

**Fee-for-Service Items Unique to the Workers’ Compensation Board**

The third component consists of unique fees the Workers’ Compensation Board recognizes, but are not part of the MSP system. These are for two major functions: the submission of forms, and expedited consultations or surgeries. The fee for the submission of forms is acknowledged by most interviewees to be required but some believe it to be excessive. It is the last component that gives the impression of a two-tiered system since injured workers may have more rapid access to clinical care than individuals injured outside the work environment. Expedited reviews
and surgeries are financially beneficial to the consultants involved. They are reimbursed under a sessional payment, usually in amounts of $800 to $1200 per 3.5 hours (compared to approximately $350 to $400 per session for a specialist in the MSP system). The argument for the expedited consultations and surgeries is that early intervention and treatment will enhance the speed and durability of return to work by an injured worker. However, there is a perception of an inequitable two-tiered system with workers receiving faster access. The Ministry of Health and many others are particularly concerned regarding the political and ethical issues raised by this approach.

This is a particularly complex issue and one which falls outside the mandate of this commission. It raises concerns about the quality of care provided to injured workers and non-workers by highlighting the inter-connectedness of the workers’ compensation and healthcare systems. It also raises concerns about value for money: the board’s arguments in favour of its approach would carry more weight if it could produce reliable, reviewable data on the outcomes of its return to work initiatives, rather than anecdotal commentary.

**Human Resources and Staff Training**

There are several relatively new factors critical to Medical Services’ human resource planning. Even if nothing else changes, the fact that more than 50% of board physicians are now over 55 years of age (some are over 65) presents both a service and recruitment challenge to the department. This challenge is strengthened by the newly-implemented case management initiative, the addition of nurse advisors to the board’s medical staff, the need for team-oriented diagnoses and therapies, and the growing importance of research.

Finding recruits to meet service needs will not be easy; individuals with advanced training and qualifications are rare and in demand. The first step in meeting this challenge is to identify the skill set needed in new recruits; however, the commission found no evidence that this had been done.

**Qualifications**

The qualifications and competence of board medical staff was of particular concern to many injured workers. There are two types of registrations relevant to physicians and specialists:

- registration with the College of Physicians and Surgeons of British Columbia, which is required for all physicians, generalists or specialists, if they are to practise in the province; and
• registration with the Royal College of Physicians and Surgeons of Canada, for those who have taken four or more years past their MD degree and wish to use the granted specialist’s certification.

All physicians affiliated with the Workers’ Compensation Board have appropriate registration in the College of Physicians and Surgeons of British Columbia, although their qualifications vary. While the majority of board physicians are general practitioners, some have their certificates in Occupational Medicine. None of the employed staff are fellows of the Royal College of Physicians and Surgeons of Canada in Occupational Medicine. Many of the physicians who consult for the board or attend clinics in the Rehabilitation Centre on a sessional basis have their fellowship qualifications.

The medical advisor job description was reportedly revised in December 1997. The update provides a clearer indication of responsibilities.

Training

Medical Services staff have been involved in project teams for case management, E-file, clinical practice guidelines and continuum of care. The board reports that initiatives ensure medical staff have input and it provides them with an opportunity for “learning, skill development, and service improvements.” In addition, with the roll-out of ASTD claims to Area Offices, all Area Office medical advisors reportedly received ASTD training in preparation for the implementation.

The Critical Success Factors listed for Medical Services in the 1998 Business Plan included the statement that:

It is critical to have the appropriate human resources available at the right place at the right time. The need for technological training for support staff and physicians will continue in 1998. Additionally, in a manner parallel to decentralizing ASTD claims to area offices and Lower Mainland SDLs’ it is expected that the skill sets of medical advisors will be expanded to include Permanent Functional Impairment advice to the Disability Awards Department. The Medical Services department will work closely with Disability Awards and others to improve the system for providing advice on disability.

Although the new contract includes a requirement for continuing medical education, there is a feeling among some of the medical staff that education is not truly encouraged at the board.
Apart from formal education, the types of education activities that should take place include:

- learning from colleagues at the board, including
  - feedback on management of cases;
  - sharing of findings on literature reviews for specific injuries or diseases; and
  - active participation in regular medical rounds;
- active use of the Internet and medline searches;
- attendance at leading national and international conferences at which some of the experiences of the board should be presented; and
- publication of research findings in peer-reviewed journals.

Commission research found very little evidence of any of these types of activities.

Work Environment

The commission’s research found that morale in Medical Services Department is, in general, low, resulting from anxiety about the future and frustration with an apparent lack of insight into the clinical issues facing them on the part of senior leadership which stresses the importance of managing finances. Staff do not feel supported by the board in obtaining and analyzing clinical data in order to make more evidence-based decisions.

Workers’ Compensation Board Physician Salaries

The level of payment of the physician employed at the Workers’ Compensation Board is mainly an issue of equity with other workers’ compensation physicians in other provinces, and to a lesser extent, the comparative income within British Columbia. Some of the Workers’ Compensation Board physicians have remarked on the inadequacy of the salary level. There are other aspects of remuneration such as roles and responsibilities, seniority and performance.

PERFORMANCE MEASUREMENT AND ACCOUNTABILITY

Measurement of Activities and Outcomes

The development and maintenance of appropriate information systems seems to be an ongoing issue for the board. Inadequate management information is an issue at many levels of the organization, as well as in Medical Services. There is no management information system for the department, and no documentation that one is planned. The review has found that a limited range of performance
information is supplied to Medical Services; activity-based data is available, client-based data is not. There is a manual quality assurance process in place. It is difficult to plan adequately, assess achievements, or prepare for future contingencies in an information vacuum.

The Rehabilitation and Compensation Services Divisions’ 1995 Business Plan listed the departmental key outcomes as medical examinations, medical opinions and worksite visits. These appear to be utilization statistics, however, rather than outcome measures.

For Medical Services, the timeliness of opinions and examinations is reported year to date. Compensation Services’ Performance Reports include data on queues for medical services for the Lower Mainland and Area Offices. Data are also available on the number of medical opinions, exams and visits completed year to date. The Rehabilitation and Compensation Services Divisions 1998 Business Plan contains budgets and forecasts for the number of examinations, opinions, work site visits, and the timeliness of opinions, exams, and ratios of medical advisors to exams, opinions and work site visits.

**Performance Indicators**

Performance indicators should demonstrate if established goals are being achieved or if there are variations from those goals. Given there is a clinical component to the mandate for the board, there should be clinically-relevant performance indicators recorded on a regular basis. Although the commission applauds the concept of the continuum of care and the board’s new relationship with external partners, the performance indicators chosen for those efforts illustrate how little clinically-relevant information is being collected. The performance indicators used in a recent review for the provider partners are:

<table>
<thead>
<tr>
<th>KEY PERFORMANCE INDICATORS</th>
<th>OTHER PERFORMANCE MEASURES</th>
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<tbody>
<tr>
<td>return to work at discharge</td>
<td>customer satisfaction</td>
</tr>
<tr>
<td>return to work three months post discharge</td>
<td>a variety of timeliness statistics</td>
</tr>
<tr>
<td>client satisfaction</td>
<td>a variety of utilization statistics</td>
</tr>
<tr>
<td>treatment duration</td>
<td>financial statistics</td>
</tr>
</tbody>
</table>
From this list, it would be hard to know, for example, how many patients with fractures have a residual functional impairment, or how many patients with low back pain continued to require some ongoing support. These two examples illustrate that performance indicators chosen to date are clearly oriented towards utilization and costs, with only one measure, client satisfaction, related to clinical outcomes.

The Association of the Workers’ Compensation Boards of Canada in its 1996 report, *Clinical Pilot Study of Biopsychosocial Measuring Instruments* (part of the *Multivariate Prediction of Disability: Low Back*) noted:

> For any prediction of disability to be valid, it is essential that the measurement tools be reliable (repeatable) and valid (true to the task). This would apply to medical or psychological assessment, or to any other data collected in a workers’ compensation system. If assessment tools are not sound (reliable and valid), results that follow will be spurious (inaccurate and mistaken). Critical and costly decisions in workers’ compensation boards rest on informed data. In the case of WCB BC, results from a recent LOE low back retrospective study demonstrate that optimal data in the system could account for only 21.7% of the variance in long term disability. Accordingly, 78.3% of variance was unexplained—that is, the Board’s current data is grossly inefficient to understand what drives disability in this population. Without knowledge there cannot be effective case management and rehabilitation, as well as fair and equitable adjudication.

**Information Systems Relevant to Clinical Care**

There appears to be a significant lack of clinical information retrieval systems with which to ask questions and garner clinical evidence. There are significant amounts of data available in the charts but these are not easily accessed and converted into information. There are computer systems established for financial management but these are not useful for clinical questions. Interviewees stated that the current design for a clinical information system is not comprehensive nor reflective of the needs of the clinical mandate of the board.

**Quality of Care**

**Guidelines**

The board appears to be developing guidelines for medical services, although its approach to evaluating care has been limited. Board physicians told commission researchers that community practitioners often do not have well coordinated or planned approaches to care for injured workers. Much of the published literature
states or implies that adhering to guidelines improves the quality of care and the efficient use of resources. *Bona fide* medical complaints can be appealed to the board’s medical review panel. Currently, many of these appeals are decided in favour of the worker, which raises issues regarding the quality of diagnosis and medical decisions.

### Monitoring Quality

The board is accountable for the professional performance of its ‘employees’. It also enters into contracts with other external care providers. These require adequate performance or, presumably, the contract will not be renewed. However, interviewees described the evaluation mechanisms for the quality of care provided by physicians at the board as “rudimentary.” Commission research found that the concept of continuous quality improvement was supported by the board although it was difficult to determine how the concept is being applied.

The board has made a number of very significant changes in a short period of time, which individually and collectively may have profound impacts on the quality of care provided to the injured worker. These changes, including replacing medical advisors with nurse advisors, modifying the role of medical advisors, placing greater reliance on community physicians, adopting an early intervention “continuum of care” approach, and tying the new roles and processes together under the case management umbrella, are all being implemented concurrently (and for claimants with the most serious occupational injuries and diseases). The effects of these changes on workers and employers, both intended and unintended, will need to be closely monitored.

### Client Satisfaction

A small satisfaction survey was conducted in 1994 with Medical Services Department clients. The survey found that clients were comfortable with the structure and conduct of their examination, agreed or strongly agreed that the doctor explained the purpose of the examination, and felt the doctor treated them with respect and courtesy. About three in four respondents agreed with the recommendations of the doctor.

Recent Angus Reid *WCB Claimant Satisfaction* surveys have also been collecting data on satisfaction with board doctors and specialists. The data is collected from clients only; there are no satisfaction surveys distributed to community practitioners. However, the board has identified this as an area for further work.
In its submission, the BCMA expressed dissatisfaction with the board, while at the same time acknowledging that the proposed fee-for-service agreement between the board and BCMA should address some of these concerns. The submission also stated:

WCB patients most often raise the following four concerns: poor communication from the WCB, inconsistency of case managers, non-physician care decisions, and long waiting periods.

**Costs of Medical Services**

The *Summary of Administrative Operating Expenses 1995-1998* shows a significant decrease in staffing levels for 1998 compared to previous years.

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<tbody>
<tr>
<td>FTE-staffing level</td>
<td>773</td>
<td>71.3</td>
<td>63.9</td>
<td>49.3</td>
<td>(30.8%)</td>
</tr>
<tr>
<td>Salaries &amp; Payroll</td>
<td>7,477,451</td>
<td>7,114,231</td>
<td>6,526,388</td>
<td>5,406,346</td>
<td>(24.0%)</td>
</tr>
<tr>
<td>Budget Reduction</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>360,000</td>
<td>***</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>8,342,631</td>
<td>7,958,389</td>
<td>7,284,626</td>
<td>5,849,333</td>
<td>(26.5%)</td>
</tr>
<tr>
<td>Cost Transfer</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,937,982</td>
<td>***</td>
</tr>
<tr>
<td>Net Expenses</td>
<td>8,342,631</td>
<td>7,958,389</td>
<td>7,284,626</td>
<td>3,911,351</td>
<td>(50.9%)</td>
</tr>
</tbody>
</table>

The draft *1998 Business Plan* assumes that increased emphasis on early intervention and continuum of care will result in the need for fewer physical examinations and file reviews.

In line with this, the board has reportedly implemented a retirement policy; up to six medical advisors are expected to retire and will not be replaced. Their workload will be picked up by staff currently involved in permanent functional impairment work. This measurement, in turn, will be contracted to an outside firm in an effort to address charges of possible conflict of interest and lack of objectivity. Disability awards is also making process improvements to get more timely and accurate decisions; this reduces the need for three to four medical advisors.

**Cost-Effectiveness**

Although there have been sporadic attempts to grapple with cost-effectiveness, there are few examples of cost-benefit analyses available. The difficulty is the department’s limited ability to identify relationships between input and outcomes; virtually, no client-based outcome data is available to the department.
In interviews, the board confirmed that the cost-effectiveness of its medical advisors can not be determined. Provider comparison software, part of the Risk Data Project, is also expected to help the board with cost-of-care analysis (e.g., by type of provider and type of intervention) but, at present, the department can look only at management costs such as the ratio of medical advisors to claims (even this is not done on a financial basis).

The Orientation Manual for WCB Physicians comments:

Cost-effectiveness—Methodology for analyzing the cost and effect of each medical advisor activity needs to be developed.
Psychology Department

Mandate

Although the terms “psychology” and “psychologist” do not appear in the Workers Compensation Act, the board has advised the commission that the Psychology Department operates under Sections 21(1), 21(6) and 56 of the Act. The board interprets “personal injury” to include psychological as well as physical injuries.

A 1995 document describes the mandate as follows:

The Workers’ Compensation Board is to provide for the safety, protection and good health of workers, with the Psychology Department primarily addressing injured workers and their dependents in the course of the commitment to provide rehabilitation and compensation services, as well as vocational training to workers who are injured or suffer from an occupational disease. The Workers’ Compensation Board also delivers services to victims of criminal acts, in part through the programs of the Psychology Department.

Mission

The Psychology Department was established 20 years ago to consult on cases where psychopathology was evident and where malingering was suspected. Since 1993, there has been an increase in the demand for, and range of, psychology services and, according to the department’s current mission statement, the department:

will serve workers, employers and the WCB by providing accurate psychological diagnosis services, effective intervention, education and responsible consultation for quality rehabilitation as well as workplace injury prevention. The provision of psychological services is guided by the highest professional principles.

According to the Department Policy and Procedure Manual, the department provides services to workers with chronic pain, head injuries, and those experiencing emotional difficulties as a result of physical injury or emotional trauma in the workplace.
The department employs a biopsychosocial model for assessing client health status. Such a model moves the treatment of clients beyond forensic or medical models into a more holistic one that recognizes the multiplicity of factors determining well-being. Psychologists (PhD) and psychometrists (MA) within the department have both a medico-legal role and a counseling role. For example, they may advise claims adjudicators and rehabilitation consultants on the psychological effects of an injury, or departmental staff may conduct aptitude or personality testing of workers to assist rehabilitation consultants in developing return to work strategies.

The department has produced the Policy and Procedure Handbook to address clinical service areas. There are also various documents that contain guidelines, including Guidelines for Medico-Legal Assessments in Psychology, Clinical Guidelines for the Evaluation of Permanent Psychological Impairment, Guidelines for Service Providers, and an Emergency Manual. The guidelines for psychological assessments follow those of the College of Psychologists of BC with respect to ethical and professional standards. According to the 1998 Rehabilitation and Compensation Services Divisions Business Plan, there is still a need “to enhance business procedures for support staff.”

Roles and responsibilities for third-party providers of psychological treatment are documented in the clinical guidelines for service providers. Proposal requirements and fees, admission criteria and other standards for service delivery are clearly laid out in the proposal package for external providers.

The Business Plan noted that, in referral practices, there is some inconsistency that needs resolving. For example, the Psychology Department’s activity levels and business profile depends on the number and nature of referrals from Compensation Services, the Rehabilitation Centre and other areas of the board. This means that policy and/or practice changes in these areas affect referrals to the department. It also stated that current board policies in the area of psychological impairment are sometimes different than existing practices.

A comprehensive review of policies, procedures and practices in compensation services as they relate to psychological impairment and treatment would greatly assist to alleviate inconsistencies, improve service levels in both psychology and compensation services, and make practices understandable to the stakeholders and clients alike.
Structure

Prior to inclusion in Rehabilitation and Compensation Services Divisions, the Psychology Department reported directly to the president and CEO. This reporting structure was an interim measure, and while it worked well, concerns were raised about a small operational unit reporting directly to the president.

In 1995, the department sought agency status:

The rationale for an Agency is to improve service delivery and cost effectiveness through increased management flexibilities, in return for agreed-upon levels of performance and results. The Agency model is first and foremost about "culture change" to address cost efficiencies and effectiveness and improve focus on client service. It is an attempt to implement a client-oriented culture change within a single operational/service unit in a more manageable manner, while reducing the risk associated with change at the larger organizational level.

However, late in 1996, Psychology joined the Rehabilitation and Compensation Services Divisions in order “to provide a more integrated service to its clients and customers, with the key focus on return to work.”

The department has identified staff shortages, including a shortage of managerial resources, lack of sufficient business/administrative support for daily operations, and a lack of staff for after hours and weekend services. The department has suggested that using private sector services could resolve some of these issues.

The department has also identified a need to decentralize services, particularly to the Kamloops and Abbotsford offices. Decentralized psychological service delivery was piloted in Victoria. That experience has led the department to expect a significant increase in workload, as well as a decrease in claimant travel costs and improved client service.

Independence

There have been some concerns expressed about the independence of the Psychology Department under the current structure. In its submission to the commission, which reflected the situation prior to amalgamation, the BC Psychological Association argued that:

In order for psychologists to be able to effectively serve individuals, they must not only be fair and objective, but seen to be fair and objective. This is sometimes difficult in working with people who have an ingrained suspicion of authority. People who are suspicious of the motives of others are very sensitive to any cues that might confirm their perception. Therefore it is imperative that
the WCB psychologists not only behave ethically and with integrity, but also work in an environmental setting that provides an atmosphere of privacy and confidentiality. This is the type of setting that currently exists at WCB. It would be detrimental to the work of WCB psychologists should members of the Psychology [Department] be required to integrate with other units such as the [Rehabilitation and Compensation Services Divisions], or be dispersed to decentralized locations. Under such a scenario, psychologists would find it more difficult, and in some cases, impossible, to gain workers’ trust, that they are being treated in a professional manner that is objective, based on science, and impartial.

Psychologists are members of the WCB team. They work closely together with other team members, but not so closely that they lose their autonomy. The Psychology [Department] as it now exists, is able to consult with other team members while maintaining a position, real and perceived, of fairness and objectivity.

In summary, the WCB Psychology [Department] is highly regarded for its effectiveness. Its mandate, organizational structure, and autonomy should be retained as it now exists.

Some interviewees noted the ethical and professional concerns of having clinicians, who have to offer an independent opinion, being incorporated as an integral part of Compensation Services. Interviewees also discussed the confusion that has extended for more than a year regarding whether there is one division or two. This confusion has reportedly affected staff morale. Some interviewees felt very strongly that Compensation Services and Rehabilitation Services should not be integrated, since the former, with 900 staff, dominates the latter, which has only 400 staff including those in the Rehabilitation Centre. This is seen as a major imbalance of power, with Compensation Services having the dominant, decision-making part of the alliance. “Rehabilitation is the poor cousin.”

**Strategies**

Psychology Department produces its own annual business plans. Like the other areas of the Rehabilitation and Compensation Services Divisions, it reports on historical statistics, analysis of the business environment, analysis of critical success factors, and projected statistics for the division’s annual business plans. (Note: The department was reportedly the first area in the board to develop a strategic plan.)
In Rehabilitation and Compensation Services Divisions’ 1998 Draft Business Plan, the external factors considered by the department included:

- new healthcare model;
- province wide reductions in healthcare;
- public awareness of the compensability of psychological issues;
- public and government focus on accountability;
- demographic changes in the work force;
- continuing lack of an objective measurement of pain;
- consumer rights; and
- university cutbacks.

Internal factors included:

- growing service demand;
- early and timely intervention;
- education and therapy for injured workers;
- supervised care and case coordination/disability management;
- psychovocational testing for multicultural clients;
- increased accountability;
- prevention;
- links with universities and the community;
- the interdisciplinary team approach; and
- research and outcome evaluation.

The 1998 Business Plan for the division contains budgets and forecasts for the number of new referrals and ongoing cases for the Psychology Department (objectives and actions taken to meet them are documented in the departmental business plans).

Under the divisional strategies (Client Service, Case Management, Operational Effectiveness, Refine Policy and Training, and Diversity), the following actions and initiatives relate specifically to Psychology Department:

- Client service:
  - accreditation of the internship program
  - client and referral source satisfaction survey
- Case management:
  - development of preferred providers’ network in behavioural health service delivery province-wide (PRIME to be used as a tool)
• Operational effectiveness:
  - develop corporate structure to record, manage, and report on third-party provider relationship
• Refine policy and training:
  - research and training (e.g., hosting symposiums, links with UBC and other academic institutions)
  - completion of data collection for phase one of the Multivariate Prediction of Disability project

PROCESS

Eligibility/Referrals
Referrals to the department appear to have been increasing steadily with some fluctuations caused by administrative decisions.

The department’s 1997 Business Plan (and the 1998 Rehabilitation and Compensation Services Divisions Business Plan) note that:

There is a need to alleviate existing inconsistencies among individual referral sources .... Clarification (in writing) of the Board’s policies, procedures, and practices with respect to referrals to Psychology will result in greater consistency among the referral sources and considerable service improvements.

The 1998 RCSD (Draft) Business Plan notes that “The Psychology Department tends to operate at maximum capacity with respect to workload requirements given existing staffing levels.” (p.41).

Activities
The department provides the following services:
• psychological, psycho-vocational and neuropsychological assessments for injured workers;
• consultation in case and disability management;
• crisis intervention;
• group aptitude testing;
• training;
• research; and
• education.
Board psychologists have both a medico-legal and a counseling role. The medico-legal role is to “provide an impartial and objective clinical opinion on the nature and severity of the worker’s psychological reaction to a workplace injury, accident, or event and its relationship to pre-existing functioning and concurrent factors, as well as to provide an opinion on prognosis and recommendations for intervention.”

Board psychologists are also involved in the following clinical programs:

- Occupational Rehabilitation;
- Medical Rehabilitation;
- Interdisciplinary Pain Programs; and
- Head Injury Unit.

Confidentiality

The department’s Operations Manual requires confidentiality of records and conversation, and details security practices to ensure sensitive data is not subject to breeches. The Operations Manual states that psychology-related information and documentation placed on a claim file:

- must be relevant to the claim and referral in question;
- should facilitate communication with other service providers and claims decision-makers on pertinent psychological and psycho-vocational issues;
- should limit the possibility of misinterpretation and misuse of psychological data as stipulated by the ethical principles of psychologists; and
- should be clear, concise, evidence-based and complete.

As noted in Psychology Department’s Guidelines for Medico-Legal Assessment in Psychological Practice in WCB Setting:

Prior to the undertaking of a medico-legal evaluation, the psychologist must obtain the client’s informed consent to the assessment. In the process, the psychologist ensures the client’s understanding of the nature and purpose of the assessment, deposition of the report, limitations of confidentiality, and the implications of refusal to consent to the assessment.

Some interviewees believed that workers need to be specifically informed of the types of information the board accesses and the amount and types of data that are accessible to individuals within the board and organizations outside the board. These interviewees felt that the current blanket permission to access any required information does not constitute informed consent.
HUMAN RESOURCES

The Psychology Department reports that it operates at maximum capacity with respect to workload requirements given existing staffing levels (21.6 FTEs). The department is, however, attempting to establish and maintain a competent and reliable supply of external consultants tracked through a third-party provider database.

The internal structure of the department did not change with the 1996 reorganization. (The commission has found no evidence that a review of its organizational structure took place.)

Work Environment

The department appears to have many strengths, including a positive work environment. The 1993 Administrative Inventory noted that staff at that time had a good working relationship, and that disagreement was open and did not result in distancing between individuals or the creation of factions. Staff were able to address ethical concerns with one another.

In 1995, the Agency Assessment Report described the department as a cohesive, homogenous group that works well together, within a democratic management environment, a situation that the 1998 RCSD (Draft) Business Plan suggests is still the case.

Nevertheless, concerns regarding job security, the value of the department to the board and problems with the reorganization have surfaced. As with vocational rehabilitation consultants, confidentiality is important to psychologists providing safe and effective care. In the opinion of many vocational rehabilitation consultants and psychologists, the cubicles they are currently housed in are not an appropriate setting to carry on conversations about medical and psychological issues.

Department staff also expressed some concerns over personal safety and about the comparatively low salaries for psychologists at the board. This results in difficulty recruiting professional staff. Some also argue that the board exhibited an insufficient recognition of the contribution of the department in staff cutbacks.

A 1995 report noted that:

The Psychology Department has difficulty in attracting professional staff because salaries are below those offered in the private sector. This ultimately costs the Department and the WCB in lower productivity, lack of consistency in service delivery to clients, and resources spent on recruitment, training and orientation for new employees.
In interviews conducted for the commission, it was also noted that:

The board currently has a policy of recruiting generalists from a particular field rather than individuals with specific training and expertise. This policy is entirely based on financial considerations and not on the value of professionals’ clinical judgement. Many positions are paid less by the board than by outside agencies or private practice and this contributes to staff turnover and ineffective treatment teams.

**Staff Training**

The department’s Psychology Training Program is a member of the Canadian Council of Professional Psychology Programs and of the Association of Psychology Postdoctoral and Internship Centres. Its pre-doctoral internship program received positive results from a 1995 pre-accreditation survey by the Canadian and American Psychological Association.

**PERFORMANCE MEASUREMENT AND ACCOUNTABILITY**

**Monitoring Activities and Outcomes**

The Psychology Department appears to track quality service indicators and caseload indicators. It also appears that the absence of client outcomes data is a shortcoming the department hopes to correct with its state-of-the-art third-party provider database.

Referral trends, caseload indicators, and research carried out by the department (i.e., the refinement of diagnostic criteria for chronic pain syndrome published in the Fourth Edition of the American Medical Association’s *Guides for the Evaluation of Permanent Impairment* (1993) appear to support the efforts management is making to use resources effectively and to reach informed decisions.

The department has been working with Information Services Division for two years to develop the third-party provider database. This database matches workers to service providers in their home communities, and evaluates services, capturing data on the worker (such as treatment requirements), and on therapists (such as language, gender, experience). The system will provide Psychology Department with information on outcomes, client satisfaction, board costs, return to work, and reductions in disability. At present, there is nothing comparable in the literature.
According to interviewees, the department performed well over the four to five years before amalgamation with Compensation Services Division. It always managed its budget, and played an innovative role at the board. For example, the department not only had the first strategic plan at the board, but also was the second department to introduce a client satisfaction survey, and the first to survey on a systematic basis.

However, the Psychology Department has had difficulty obtaining psychology statistics recently. The SDLs do not capture psychology statistics; and while clerical staff could do so if there were a management commitment to capture them, it appears that the commitment is not currently present.

Factors Predictive of Disability in Workers’ Compensation Claims: A Retrospective Analysis of Routinely Collected Sociodemographic, Claim and Clinical Data, (1995) whose authors include the director of the Psychology Department, notes that:

Chronic disability as a result of an occupational related low back injury is a problem with biological, psychological and social aspects (Waddell & Turk, 1992). What remains necessary is the systematic collection and examination of biopsychosocial and systemic factors known to be involved in the disability process. Identification of factors allowing for effective prediction of occupational disability will allow workers’ compensation boards to collect clinical, claim and systemic information that is truly relevant for the prediction of disability. Current routinely collected file information does not allow for the building of an effective predictive model of occupational disability; the results of the prospective study to follow this pilot are expected to fill this critical information gap.

Effectiveness/Client Satisfaction

The Psychology Department's 1997 Service Quality Survey Results show that in 1997 and 1996, adjudicators’ overall ratings of the department were very positive. Surveys of referral sources have also indicated high to very high levels of satisfaction with the timeliness and quality of psychological service.

Reportedly, appeals are not generally driven by dissatisfaction with the psychology services; commission researchers were told that very rarely have cases been appealed for these reasons.

Some submissions to the commission identified the lack of psychological services as an area of concern. For example, submissions raised:

• the lack of psychological services to address the needs of first nations people;
• the need for counseling on how to manage stress;
• the need to consider psychological effects of injury; and
• denial of external psychological services originally approved by the board.

According to the board, the department has undertaken a number of steps to promote sensitivity to ethnicity and cultural differences.

**Resources and Cost-Effectiveness**

The business plans for the Rehabilitation and Compensation Services Divisions include cost/benefit figures for a variety of initiatives, as well as budget worksheets; however, financial data for the Psychology Department are not identified separately. Instead, the department business plan and quarterly reports include financial accounting information. Service unit costs were not clearly detailed in the reports available to the commission’s researchers.

Productivity and efficiency objectives are identified in the 1998 Rehabilitation and Compensation Services Divisions *(Draft)* Business Plan. The Critical Success Factors stated for the department include service quality standards, timeliness, and client and referral source satisfaction, as well as:

- **productivity**—retaining clear productivity standards in the Department (already in place) and monitoring service unit costs; any increases in unit costs can only be justified by:
  1. increased service complexity
  2. increased service quality
- **innovation**—promoting service initiatives resulting in heightened consumer outcomes and cost reduction (e.g., increased emphasis on cost-effective case management)

The decision to use internal rather than external service providers reportedly revolved around costs; the estimated costs of doing an assessment internally, including facilities, utilities, secretarial staff, and other overheads, was substantially less than the cost of an external assessment.

After reviewing its research reports, the commission has concluded that the “true costs” of services remains a matter for investigation.
The Leslie R. Peterson Rehabilitation Centre

Mandate, Mission, Structure and Strategies

Mandate
The Leslie R. Peterson Rehabilitation Centre is located in Richmond and operates pursuant to Sections 16, 21 and 56 of the Workers’ Compensation Act. Section 16 relates to providing vocational rehabilitation services; Section 21 concerns the provision of medical aid; and Section 56 defines the duties of physicians or practitioners. These sections jointly provide the Centre’s mandate.

Mission
The Rehabilitation Centre has a clearly stated mission.

We provide quality rehabilitation to assist employers and injured workers in achieving safe, early, effective return to work.

The Strategic Plan 1995-2000 and Business Plan 1995 for the Leslie R. Peterson Rehabilitation Centre includes in addition to the above mission statement, a statement of the Centre’s vision, values and strategic principles.

The Centre’s vision statement reads:

We are North American leaders in returning injured workers to productive employment through rehabilitation.

The Centre attempts to achieve its vision by:

• leading an efficient network of rehabilitation providers
• managing an effective continuum of care
• being a centre of excellence in research, development and teaching
• being a provider of direct clinical service
  (a) where a developmental need exists
  (b) as prototypes for all services we oversee.

The Centre’s Statement of Core Values and Beliefs states the following:

• We believe that cost-justified rehabilitation is preferable to compensation.
• We believe our rehabilitation and assessment services to injured workers must meet the highest ethical and professional standards.
• We see the injured worker and their injury employer as our primary clients.
• We see working as a defining characteristic of normal functioning for our clients, and return to work as our ultimate and most important goal.
• We assume the injured worker has been unable to return to normal functioning because of a range of complex and interacting medical, physical, psychosocial and vocational factors. We see overcoming barriers to employment arising out of these factors as our challenge.
• We consider a biopsychosocial approach as essential in the understanding and rehabilitation of individuals who have incurred workplace injuries.
• We see workers and employers as central to the process of rehabilitation.
• We believe that continuous improvement, which is central to our mission, implies ongoing clinical research, program evaluation, and innovation.

Structure

Until 1996, the director of the Leslie R. Peterson Rehabilitation Centre reported to the senior executive committee which, in turn, reported to and was chaired by the president and CEO. Alternative structures have been considered in recent years, including a vice-president of rehabilitation with a director, Rehabilitation Centre, reporting to the vice-president.

In the second quarter of 1996, the Rehabilitation Centre, along with the Psychology Department, was restructured into the new Rehabilitation Division which reports to the vice-president, Rehabilitation and Compensation Services Divisions. This structure was to “complement the programs and initiatives being undertaken by [the board] such as the focus on early intervention, disability management, the continuum of care, clinical practice protocols and case management.”

The restructured Division was to focus on returning injured or occupationally-diseased worker to employment through clinical and vocational rehabilitation. Although it was originally planned that the Vocational Rehabilitation Services Department would become part of Rehabilitation Services, it has remained, and continues to remain, part of Compensation Services. The Centre is currently run by two directors: one concentrates on administrative issues, the other on program and research matters.

Strategies

The Centre has a history of effective planning, first independently, then as part of the division. The Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation process has contributed to this planning process.
The Centre’s planning documents identify goals and objectives. Measurable outcome-focused targets are not always listed in the planning documents but may be found in program evaluation documentation. Planning is done in the context of reasonably-extensive research so the Centre appears to be cognizant of the challenges it faces when planning programs.

The Centre’s Strategic Plan 1994-1999 (Fall, 1994) noted that:

Currently, the Board’s approach to rehabilitation is unfocused with service delivery fragmented along divisional lines. Vocational Rehabilitation, under the umbrella of the division whose primary business is paying compensation, is in a separate “world” from clinical rehabilitation. Case management is scant, and early intervention procedures are not well developed. Further, the Board is late in developing effective policies and procedures for working effectively with external providers of rehabilitation programs.

In the 1995 Compensation Services Business Plan, the priority for rehabilitation was that the quality and outcomes of rehabilitation would meet or exceed international standards for professional rehabilitation and cost-effectiveness. Strategy one under this priority was that all rehabilitation activities would become outcome-oriented. Actions would include regular external bench-marking, conducting post-discharge and in-treatment surveys, and undertaking cost/benefit analyses of selected rehabilitation services. Strategy two was achieving accreditation first for the Functional Evaluation Unit (FEU), the Back Education and Evaluation Program and the Hand Unit, then moving on to other programs. Strategy three was forming partnerships for effective treatment closer to home. The final strategy was the development of better treatments and outcomes through research.

In March 1995, the Rehabilitation Centre was accredited by CARF for a three-year period for the Functional Evaluation Unit and Back Education and Evaluation Program. The objective was to have all Centre programs accredited in 1998.

Early intervention, the “continuum of care,” management of external care providers, developing the Rehabilitation Centre as a “centre of excellence,” and improved management information and monitoring of outcomes remained important elements of the Centre’s strategies through 1997 and 1998. The Rehabilitation and Compensation Services Divisions’ 1998 Business Plan identified internal and external factors affecting the Centre, including:

- new work environments with a change in the types of injuries/conditions seen by the Centre;
- demand for more accountability from public sector organizations;
technology to improve information capture and communication about clients; demographic changes (increase in cultural diversity, average education level, and average age);

increasing emphasis on health services “closer to home”;

increase in the range and number of private rehabilitation providers;

more synergy between the Centre and the other divisions;

return to work becoming a more important corporate goal; the board becoming more client-focused; and

the board’s evolving rehabilitation strategy (i.e. establishing disability management and integrated care supervision).

Under the five 1998 divisional strategies (Client Service, Case Management, Operational Effectiveness, Refine Policy and Training, and Diversity), the 1998 Business Plan lists the following initiatives specifically for the Rehabilitation Centre:

- Client Service:
  - CARF Accreditation

- Case Management:
  - Maturation and expansion of external provider network. Invite major providers to create a partnership with the Board, in order to facilitate provision of localized rehabilitation services to claimants throughout the province
  - Re-engineer Medical Rehabilitation and specialty services
  - Final development and roll-out of external ASTD programs

- Operational Effectiveness:
  - Complete the Service Improvement Strategy
  - Physical integration of Programs

- Refine Policy and Training:
  - Develop clinical research database
  - Formalize educational offerings

**PROCESS**

**Activities**

Traditionally, the Centre provided direct rehabilitation services to board clients in facilitating re-employment of workers experiencing significant barriers in returning to work. In particular, the Centre provided specialized treatment services not readily available elsewhere. It also provides high-quality assessments of clinical conditions and functioning, as they relate to employment. In order to do this, the centre operates eight interdisciplinary clinical programs:
• *Work Conditioning* provides early reactivation and general conditioning;

• *Occupational Rehabilitation* develops treatment plans to address barriers to return to work, may include work simulation, psychological counselling, job site analysis, etc.;

• *Interdisciplinary Pain* provides treatment for clients with chronic pain;

• *Medical Rehabilitation* provides assessment and treatment for clients with outstanding medical issues, includes treatment for clients with amputations;

• *Worksite Reintegration* identifies workplace re-employment barriers and supports integrating clients back into the workforce;

• *Hand* provides treatment for clients with acute or chronic hand/wrist injuries;

• *Head Injury* provides assessment, planning, and case management for clients with mild or moderate head injuries; and

• *Functional Evaluation* assesses a client’s ability to return to work, and provides related education and counselling.

Interdisciplinary teams can include physical and occupational therapists, as well as specialists from medicine, psychology, vocational evaluation, vocational rehabilitation, and nursing.

The Centre’s eight programs are supported by a number of resources including industrial workshops, a residential facility and a health unit. The Program Evaluation and Research Unit works with management and staff to conduct evaluations and to develop performance measurement reporting.

The centre’s traditional role was that of a virtual monopoly, providing the only outpatient multidisciplinary rehabilitation service available to the board. Recently, the centre’s role has changed from that of primary service provider to the manager of a province-wide network of service providers and 140 external programs. As a consequence, some injured workers are able to receive treatment from independent health-care professionals closer to the worker’s community. The centre continues to provide services, but to a smaller population.

The Rehabilitation Centre provides the continuum of care to “increase, on aggregate, return-to-work rates and client satisfaction and to reduce claims duration, disputes and appeals.”

In order to ensure that clients receive timely treatment in the appropriate program, the … Rehabilitation Centre has developed a sequence of treatment interventions called the Continuum of Care. During the initial acute period (up to four weeks post injury) workers are left to the care of their attending physician. A number of
studies have found normal resumption of activities to be the most efficacious treatment for acute low back pain ... These studies all suggested exercise therapy provided too early within the course of a soft tissue injury may only delay recovery and contribute to further disability.

Workers still unable to return to work after this period and who have hand or wrist injuries, repetitive strain injuries or complex musculoskeletal injuries are triaged towards special treatment programs. The remaining workers enter a sequence of interventions referred to as the Continuum of Care....

Those clients unable to return to work following this intervention are generally enrolled in a program called Occupational Rehabilitation ... Clients who present with a strong focus on their pain or who are unable to return to work after occupational rehabilitation may be entered into a pain management program....

The Early Intervention Program System, an electronic system which monitors claims of workers with soft tissue injuries, is designed to route clients into the continuum of care. Workers are contacted early in the claim and encouraged to pursue rehabilitation services before permanent disability develops.

PERFORMANCE MEASUREMENT AND ACCOUNTABILITY

Quality Control

The 1993 Annual Report of the Leslie R. Peterson Rehabilitation Centre states that:

The Rehabilitation Centre concurs with the need to address the administrative inventory’s attention points and has begun doing so. In seeking CARF accreditation, the Centre has embarked on systematic development that will strengthen all aspects of its operation. We’re working to enhance results in the following four areas:

• Client satisfaction
• Timeliness of service delivery
• Cost-effectiveness
• Service quality

Managing to meet CARF standards has already had an impact on the Centre’s operations.
CARF accreditation according to the *Annual Report*:

is an internationally recognized designation that assures clients a rehabilitation centre adheres to high standards of practice. CARF standards and principles of quality service and sound administration have been developed with the help of more than 40 organizations representing professionals, consumers, and experts. CARF accreditation will confirm that the programs at the Rehabilitation Centre have been independently surveyed and meet the professional standards of practice.

Accreditation was awarded for the Functional Evaluation Unit and the Back Education and Evaluation Program in 1995 for a three-year period. Having all programs accredited by the end of 1998 was still an objective of the centre.

The *Strategic Plan 1995-2000 / Business Plan 1995* (February, 1995) indicates that the centre's staff has a considerable potential for fostering change and innovation. This is seen as a strength, while weaknesses, referenced by the Plan, include staff imbalances in key areas, significant change initiatives affecting staff morale, and lack of experience or skill in teamwork. Also mentioned is the opinion in some areas that the centre is a dumping ground for very difficult cases.

The same document identifies stress related to change in the past two years and continued confusion over role and professional identity as threats to the centre’s development. It noted that further changes must be managed well so that staff understand the benefits of change and support the initiatives. Both the 1997 and 1998 business plans acknowledged staff anxiety related to changes at the Centre.

There has also been some concern about the hiring and retaining of certain professional groups. For example, it appears that the greatest turnover in staff is experienced in the physiotherapy and occupational therapy areas where the board does not provide competitive salaries. As a result the Rehabilitation Centre is “forced” to hire new graduates. Once these graduates acquire experience, they often leave to work in private practice.

**Effectiveness**

The Program Evaluation and Research Unit has provided an enormous amount of evidence on the centre’s ability to achieve its objectives. Its reports were made available to the commission’s research team. A review of a sample of these reports indicates that the unit has prepared program evaluation reports per quarter by program; client satisfaction surveys and client feedback questionnaire findings are available for selected programs and varying timeframes. The reports present
intended and actual performance. Assumptions and other data qualifiers are included in some reports. The unit also uses results to assess client and customer needs and to determine future directions for the centre. Included with one quarterly unit report was an action plan response form, with actions planned or in progress (findings, target dates, persons responsible and utilization categories).

Although the commission could review only a sample of the unit’s reports, it appears that the centre’s programs are successful. This view is supported by the fact that, although there is considerable variation by program and by stakeholder group, satisfaction with the programs offered by the centre appears to be high.

The centre appears to respond to the results of research, community consultations and other environmental trends in an effort to keep its programming relevant. Examples are:

- using multidisciplinary teams to treat chronic pain clients;
- decentralizing rehabilitation services through the certification of 65 private physiotherapy clinics to provide work conditioning programs; and
- using a time-based continuum of care and focusing on early return to work.

The following table shows three different outcomes for a variety of programs.

<table>
<thead>
<tr>
<th>Program</th>
<th>Injury to Admission</th>
<th>Fit to RTW at Discharge (%)</th>
<th>Durable RTW % (3 mos post discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
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<tr>
<td>Work Cond</td>
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<td>66</td>
<td>54</td>
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<tr>
<td>Occ’l Rehab</td>
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<tr>
<td>Med Rehab</td>
<td>246</td>
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<td>268</td>
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<tr>
<td>Hand</td>
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<td>Head Injury</td>
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<tr>
<td>Fun Eval</td>
<td>1,095</td>
<td>1,022</td>
<td>767</td>
</tr>
</tbody>
</table>

Notes: N/T = Not tracked at this time
N/A = Not applicable

“Fit to return to work at discharge” measures the percentage of clients able to return to work at end of treatment. This contrasts with the “durable return to work” indicator which measures the percentage of clients, who, 3 months after discharge, are still working. The ongoing focus in the Rehabilitative Centre is to increase durable return to work as it results in increased cost savings for the board in the long run.
Even with the wealth of evidence produced by the unit, key indicators are not tracked for all programs and additional data is needed by the centre. The Rehabilitation and Compensation Services Divisions 1998 Business Plan (Draft) identifies one of the weaknesses for the Centre as “inadequate management information available to make timely decisions.”

Developing and maintaining appropriate information systems is an ongoing issue for the board. A legacy of cumbersome, independent non-integrated systems, combined with competition for central Information Systems Division services, is the perfect environment to spawn quick-fix departmental systems. The centre has experienced some of the problems related to this type of environment. The unit stepped into this breach in 1992 and provided some of the resources and expertise required.

Cost-Effectiveness

The commission found little evidence with which to determine whether or not the Rehabilitation Centre was achieving its objectives in a cost-effective manner. Some documents refer to the cost-effectiveness of specific Centre programs; however, comparisons between internal and external programs are complicated by differences in the client populations receiving treatment. The Rehabilitation Centre is also constrained somewhat in its ability to identify and analyze input/output relationships by the organizational legacy of independent information systems. The CARF report did not refer specifically to cost-effectiveness.

The centre reports that some attempts have been made to conduct cost-effectiveness analyses. The centre’s 1994 Annual Report noted that workers who participated in the 1994 Repetitive Strain Injury Early Intervention Pilot Project did not reopen claims at six months after injury. It suggested that these results are promising and could lead to considerable cost savings for the board.

The 1994 senior executive committee minutes state that:

The FEU and BEEP projects are cost-competitive with outside agencies. The Work Hardening program has not been competitive to date due to volumes. Better utilization would increase competitiveness. The Residence is competitive. The Hand Clinic and Amputee Unit are more costly, but due to volume of cases, there is a great deal of expertise required and this translates to higher costs.
In a 1996 Compensation Services quarterly performance report it was stated that the Amputee Unit was consolidated with the Medical Rehabilitation Program as the Amputee Unit was no longer cost-effective as a single program.

In an interview with commission researchers, it was reported that the centre has good information on costing (e.g., salaries, physicians, cost of specific programs). The full costs of the centre are reportedly known, including depreciation of the buildings, utilities, and all staffing costs. For individual programs, these overheads are broken down by either the percentage of the facilities used by a program (floor space) or by an even division (e.g., the Program Evaluation and Research Unit). Thus, managers know the full costs of their programs. Generally, indirect costs (facilities, depreciation, central administration, Program Evaluation and Research Unit, central records) comprise 50% of costs, and direct costs (staffing, mailing, telephone, transportation, education, conferences etc.) comprise the remaining 50%.

In other interviews, however, it was suggested that the division as a whole is still a long way from activity-based costing, and that staff to date have not appropriately captured the cost of items such as facilities, governance, overheads, length of work week, time off, and staff benefit packages.