Review and Assessment of the Administration of Medical Affairs at the British Columbia Workers’ Compensation Board

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EXECUTIVE SUMMARY

A review of the medical staff and medical staff function was undertaken as part of the Royal Commission on Workers' Compensation. Information was collected by interviewing individuals and reviewing documents. There are about 50 salaried physicians in the WCB, acting mainly as medical advisors to claims adjudicators, as diagnosticians and therapists for the more complex injured worker or chronic pain sufferer, and as Occupational Health and Prevention physicians. They are all registered with the College of Physicians and Surgeons of B. C., mainly as general practitioners. Some have advanced certifications or specialty fellowships. However, routine evaluations of quality care are not performed.

The major responsibility for the care of the injured worker rests with the attending physician in the community, who bills the WCB for the services rendered on behalf of the worker. Some non-WCB specialists come to the Rehabilitation Clinic or see patients in their offices for the more complex injury.

Several significant findings were observed:

• the WCB physicians generally have a poor or mediocre image amongst the community physicians and the injured workers. The physicians are not perceived to be resources, knowledgeable of current literature, and their involvement in the care of the patients often comes late being reactive after problems are engrained;

• the morale of the physician staff is low as many are anxious about the future and frustrated by lack of direction;

• the mission, vision, purpose, goals and objectives are not clear and are not shared by the physician staff; neither is the role of the physicians in the organization;

• the medical staff are not perceived to be, nor are they expected to be, leaders within the WCB, or, in fact, outside the WCB;

• the clinical outcome of the injured worker is not understood; nor is it apparently valued, when it comes to data gathering and short or long term evaluation;

• the environment within the WCB appears to be one where adequate interaction does not occur, nor is it encouraged, where physicians are isolated from one another and from the outside experts, and where education, learning and knowledge receive minimum or token support; and

• recommendations from numerous reports have not been implemented in the long term which, with the rather frequent changes in leadership, have left a feeling of uncertainty, lack of direction, and inability to act or make changes.

In order to resolve these issues, the central mandate of the WCB must be examined, and emphasis on the clinical care of the injured worker needs to be reinforced. The supportive roles of compensation and prevention of injury and disease are important, but secondary roles after the clinical care of the injured worker is addressed. Therefore the WCB must reinforce its mandate as a provider of clinical care to the injured worker, some directly but mainly indirectly through other providers. The risk of managing the WCB driven predominantly by financial strategies, analogous to the what happened with the management of the blood supply system, would be completely avoided.

The role of the WCB will influence the role of the physician. As a clinical care organization with a major Provincial leadership role, it must become a clinical leader in the care of the injured worker, develop credibility as a resource for expertise in clinical care, utilize standard guidelines, be proactive, and act as a clinical and educational resource to the health care providers in the Province. This implies
the use and dissemination of clinical practise guidelines, and the monitoring and improvement of them over time. The history, therapy and outcome of the injury to the worker must be known so that improvements can be made. This implies the need for a clinically oriented information system. As the mandate expands so too must the role of the physicians. Physicians should be clinical experts in injury or occupational diseases, be credible resources to outside clinicians, support and disseminate guidelines, address issues of utilization management and continuous quality improvement, support research, and provide knowledgeable and unbiased information to adjudicators and case managers.

As a Provincial resource, different skill sets will be required by the physicians; a Medical Human Resource plan must be established as retirements, changes in roles and case management will change the number and type of physicians required.

Being a Provincial resource implies the need to support evidence based care, and via that, research. Therefore the WCB needs to support research endeavours on behalf of the injured worker. Outstanding questions related to rate, common injuries, cause, optimum treatment, outcomes and prevention cannot be answered at this time. Continued and active participation in the Provincial Integrated data base project should be encouraged.

Concern was expressed regarding the potential of a two-tiered system. Workers who are injured can receive expedited consultations and/or surgery. This could imply differences in access to medical care, as wait lists for non-WCB patients may be extended. Eliminating expedited reviews altogether may cause all injured patients to wait longer and receive a lesser quality of care. The complexity of the issue plus the political and ethical implications require that this issue be addressed in a coordinated manner by the WCB and its stakeholders. However, if early intervention justifies expedited review, the WCB should lead in a Province wide educational program for expedited therapy for all types of injuries.

Medical contracts using WCB funds should be developed as tripartite agreements between the Ministry of Health, the BCMA and the WCB, to ensure Provincial consistency.

The WCB must undertake active programs for utilization management and risk management. The senior executive should have representation from a medical leader in the organization. A Professional Advisory Committee should be established and the chair person should also be on the senior executive. Case Management should be expanded to all regions using anticipatory caution for potential problems.

Furthermore the WCB must be accountable for managing and implementing the strategic decisions aimed at improving its function. Performance indicators must be utilized within an accountability framework, and include clinically relevant measures.
The following table lists all conclusions in summary form.

| 1. Clarify Strategic Vision                  | 16. Continue with the Integrated Database Project |
| 2. Utilize an Accountability Framework       | 17. Review WCB Physicians Salaries               |
| 3. Create a Learning Environment            | 18. Reallocate the Additional MSP-based Increment to the Benefits Pool within the MSP |
| 5. Develop Medical Responsibilities, Accountabilities and Regular Evaluation Mechanisms | 20. Assess the Ethical Implications to the WCB Unique Fee System |
| 6. Clarify and Publicize Role of WCB and Attending Physicians | 21. Educate Clinicians Regarding the Benefit of Early Intervention |
| 7. Clarify and Publicize the Role of Treatment Team Members | 22. Develop an Outcome Oriented Assessment of Clinical Variability |
| 8. Encourage Contact Between WCB Physicians and Patients | 23. Implement Programs in Utilization and Risk Management |
| 10. Address Policy Development               | 25. Establish a Professional Advisory Committee and Include a Clinician on the Senior Executive |
| 11. Enhance the Provincial Leadership Role   | 26. Expand Case Management to All Centre/Regions |
| 12. Establish/Enhance a Clinical Research Mandate | 27. Expand the Role of Physicians within the WCB |
| 13. Utilize Clinical Guidelines              |                               |
| 14. Utilize Clinically Relevant Performance Indicators |                               |
| 15. Complete the Design of a Clinical Information System |                               |

If the above conclusions were accepted and implemented, the following changes would be anticipated. The WCB would understand what the best treatments, therapies and prevention strategies are for the workers. Workplaces would be safer, and the injured worker would make a good quality clinical recovery. As clinical caring becomes noticed, the appeals would decrease and inappropriate approvals or rejections would decrease. Community physicians would utilize the resources available in the WCB, and consequently provide a more consistent care, which would mean better resource utilization and quality of care. Physicians in the WCB would be happier, more enthusiastic and committed to the goals of the WCB. Recruiting highly qualified medical staff, who would be more productive, would be easier. The underlying goal of the WCB, to care for and improve the health of workers, would be the focus of national and international praise.
INTRODUCTION

This report will be in five major sections. The first section will summarize the current situation and the major findings from the review. The second proposes three major models that can be considered upon which to base the function of the organization. The next section will address the issue of strategic management for the organization. The fourth section is the main body of the report, related to the medical staff, their credentials, activities, and relationships of the WCB physicians. The fifth will discuss the Case Management proposal and makes suggestions where it might be improved or where to anticipate problems which might arise during implementation.

It should also be noted that the conclusions drawn during this study are based upon the information obtained. Further, in a complex organization such as the WCB, there are multiple facets to be considered, and suggestions made from the analysis in one component must be placed in the context of the whole organization as some suggestions may have organization wide impacts not understood by single component analysis.

1.0 CURRENT SITUATION

1.1 Medical Staff and Their Functions

There are about 50 physicians working for the WCB at this time. The largest group, about 30, is the Medical Advisors. Their major role is to provide advice to adjudicators regarding claims. Medical Advisors are affiliated with each regional area within the Province, including many subregions in the lower mainland. The second largest group is located in the Rehabilitation Centre, assessing patients and providing 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. There are approximately 5 physicians in the Occupational Health and Prevention group, who provide advice on causation of occupationally related diseases, and address issues within the workplace environment that could aid in the prevention of injuries or diseases. All of these physicians are salaried by the WCB. From a qualifications perspective, they are mainly general physicians, some with extra certifications.

The WCB brings in specialists to see patients particularly in the Rehabilitation Centre for particular clinical issues of greater complexity. These specialists are often Fellowship qualified with expertise suited to assessing difficult clinical issues. For example, they may be Orthopaedic surgeons, Neurosurgeons or Neurologists. They are reimbursed under a sessional payment, usually an amount of $800 to $1200 per 3.5 hours (compared to approximately $350 per session for a specialist in the MSP system).

However, the largest component of physicians who care for the injured worker are general physicians in the community, often referred to as the attending physician. There are about 3000 General Practitioners (and about an equal number of specialists) in B.C. who have variable amounts of interaction with the WCB. It is this component that is actually providing the bulk of the care to the injured worker. They are the critical mainstay of the treatment arm of the WCB. Their role is significantly complex and variable with respect to the therapeutic approach. They bill the WCB for each clinical care activity provided to the injured worker on a fee for service basis (more detail is given below in Section 4.12 on Physician Funding).
1.2 Current Tensions, Problems, and Perceptions

WCB physicians were described by many injured workers, and others, as anti-worker, biased in
favour of the WCB, and not at the leading edge of current medical practice. Many physicians and non
physicians interviewed within the WCB recognize that these are prevailing perceptions held by the pub-
lic as well as by some physicians outside the WCB.

Some community physicians do not perceive the WCB physicians as credible, as a resource to
them, or currently practicing state of the art medicine. In support of these perceptions, examples were
cited of WCB physicians becoming involved late in the care of a worker and providing a reactive
approach to care. WCB physicians are perceived as the ones who turn down claims sometimes without
doing a complete history and physical examination of the patient and without support of evidence based
practise. The quality of the medical staff at the WCB has been discussed in the B.C. Legislature as
recorded recently in Hansard (3/20/98).

In addition to the external perceptions, there are internal issues and tensions which need to be
addressed. The morale in general is low, resulting from anxiety about the future and frustration with the
lack of direction. The physicians are frustrated and disappointed by the lack of insight into the clinical
issues facing them from the senior leadership. They do not feel supported by the WCB in obtaining and
analyzing clinical data in order to make more evidence based decisions, and yet ironically, they do not
utilize an evidence based approach to manage clinical quality and resource utilization themselves. But
then again, the signals from senior management do not reinforce an evidence based approach as the
modus operandi in the clinical realm, but rather stress the importance of managing finances.

In fact, there is a perception that the WCB does not truly value the clinical outcome of the worker,
which when one assesses the signals that come from the WCB, has some definite legitimacy to the con-
cern. For instance, in the documentation reviewed for the Royal Commission was a table listing the
annual death rate according to the year of the payout. Although one acknowledges the needs of the
financial department to manage the funds, a table compiled on this basis and widely circulated implies
that the payout time is more important than the death per se. If one were to ask the family, the employer
or the unions, one would probably receive a different priority. Such signals may be subtle but they are
very far reaching.

The medical staff are not perceived to be, nor are they expected to be, leaders within the WCB. Medical leadership is critical if one is to consider the mandate of the WCB. If it is an organization with
clinical care responsibilities, then should the medical staff not be expected to be leaders?

As one senior individual said "in the past, we may have set up the physicians for failure". There
were other observations that provided support to this rather incriminating statement. The environment
within the WCB was said to be one where there are many 'turfs' and administrative 'silos', where interaction
does not occur, nor is it encouraged, where physicians are isolated from one another and from the
outside experts, and where education, learning and knowledge receive minimal or token support. The
vision, purpose, goals and objectives are not clear nor are they shared by the physician staff (and we sus-
pect by other staff) of the WCB. This leaves some of the medical staff uncertain as to what their roles
should be, and hence implies that their behaviours may be inconsistent too.

In the current situation, there is a component that reflects poorly on the senior leadership. In read-
ing numerous documents from earlier reviews and from the interviews, one is left with the impression
that earlier recommendations have not been well managed over the long term. Change in the way things
work is slow or non-existent, and falling back into the old way of doing things is the norm, not the
exception. Add to this the rather frequent changes in leadership, and it is not surprising to detect feelings

1 Presentations to Royal Commission Hearings
of uncertainty, lack of direction, and inability to act or change, ie, an inability to make a difference (at least in the medical staff interviewed during this review).

1.3 How were the above conclusions reached?

There were two major mechanisms utilized in obtaining the data and information to reach the above interpretation of the current situation, reading many documents (appendix 3) and interviewing many people (appendix 2). The interviews cannot be interpreted as exhaustive as many medical staff in the WCB were not interviewed. Nonetheless the consistency of the findings above was remarkable, and even those negative comments directed towards the medical staff internally were recognized by them as having some validity in perception.

There are admittedly some generalities in the above conclusions because there are some areas where individual physicians are respected, are attempting to be leaders, and would like to be more evidence based and proactive. Nonetheless, the generalities are applicable, and the perceptions are very strong externally. So these exceptions can be considered ‘the exceptions that prove the rule’. Within these caveats of exceptions, the reviewers are confident with the above findings, as legitimate problems facing the medical staff, and for the community of clinicians and injured workers in the Province.

1.4 How Would the Above Situation Affect the Medical Staff Function?

With the problems and perceptions detected in the current situation, what would be some of the consequences? The physicians’ role is complex, and they are very often challenged to manage in a system that is part insurance company, part clinical care, part prevention, part educational and part resource to others. There is bound to be significant tension in describing and behaving according to these potentially conflicting pressures. How would the physicians respond to these pressures? For instance, the reader is asked to consider him/her-self to be a WCB physician and try to determine "what is my role?" in following different organizations:

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>AS A PHYSICIAN, WHAT IS MY ROLE IF....?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is my role if we are an insurance company?</td>
<td></td>
</tr>
<tr>
<td>What is my role if we are to minimize expenditures within the WCB?</td>
<td></td>
</tr>
<tr>
<td>What is my role if I am to provide advice to adjudicators; and should it be impartial, advocate for the patient, or advocate for cost containment?</td>
<td></td>
</tr>
<tr>
<td>What is my role if I am to act as an adjudicator?</td>
<td></td>
</tr>
<tr>
<td>What is my role if we are to treat injured workers with injuries or occupational diseases?</td>
<td></td>
</tr>
<tr>
<td>What is my role if we are to support outside physicians and other clinicians in the treatment of workers with injuries or occupational diseases?</td>
<td></td>
</tr>
<tr>
<td>What is my role if we are to contribute to the knowledge gained in assessing injured workers to the general body of knowledge regarding rehabilitation medicine? To whom do we provide that knowledge?</td>
<td></td>
</tr>
</tbody>
</table>
Perhaps some of the conflict can be illustrated in a hypothetical case:

An injured labourer has a complex shoulder injury that will require a considerable amount of therapy to return to normal. He is however part way through a training program in computer programming and has demonstrated an aptitude. The cost for the completion of training is about $7,000 less than what it would be to complete the total rehabilitation for the shoulder, although the shoulder is certainly 'good enough' for a career as a computer programmer.

What is to be done in this situation? How are competing needs decided? If the choice is to complete the computer training, is his clinical care continued to achieve a quality outcome? If the clinical care is not continued, then is he receiving good quality clinical care? Who is responsible for his injury, or for his retraining for that matter? What should be the targeted outcome from the injury?

The WCB contributed, perhaps unknowingly in retrospect, "in the past, we may have set up the physicians for failure". The debates that derive from cases such as the one above, can and should be considered, discussed and decided upon. Not addressing them is not providing adequate and appropriate direction to the medical staff (and likely to others). That is related to addressing the strategic issues of the organization. See below, section 3.0.

1.5 Are There Some Strengths in the WCB Medical Staff?

As one would assume in a complex organization such as the WCB, one would see many strengths in a professional group such as the physicians, and one does. As above, the following findings were derived from interviews and reading, but they too are generalisable and applicable to the current situation. There are many positive qualities within the medical staff to be built upon:

- the medical staff are sufficiently qualified and skilled to provide commitment and leadership for change (although additional skills will be required for future needs);
- there is a realization amongst the medical staff that change is required, and in fact, that the current situation is one of transition;
- that clinical care is the main thrust of their knowledge base, and that outcomes and evidence based information will be required to make strides inside and outside of the WCB (this finding is accepted at a conceptual level by the physicians but it is not generally operational);
- that partnerships and multidisciplinary teams are appropriate approaches for the future, and that physicians must be members of the teams (there are some who do not agree with this statement);
- they are supportive of the new leadership recruited for the Medical Division, and of the planned attempts to change and progress; and,
- that improvement in the clinical process will only occur if there is a proactive approach to the health of the workers in B.C. (again there are some who have a hard time changing and would prefer the status quo but one should also realize the leadership demonstrated by some of the physician group with respect to the design and testing of Case Management).
2.0 POTENTIAL MODELS OF HOW THE WCB COULD OPERATE

There appear to be three major functions at the WCB. These include claims processing (compensation model), clinical care (therapeutic model) and prevention of injury and disease in the workplace (prevention model). Perhaps one should ask how all this got started and what it is that the WCB should be doing. The WCB, and organizations like it elsewhere, were created because people were getting injured and killed at work. That is, there was an incident that caused damage to the worker's health - this was first and foremost. As a consequence of the damage to health, clinical care was required. But because of the injury, income was lost to the worker; hence replacement/compensation was appropriate, (although in the Canadian system of health care, compensation for an injury was not considered a universal right as access to medical care is). Furthermore, if the cause of the injury or disease could be avoided, then there would be benefit to the worker (no personal health problem, and no loss of income) and to the employer (no loss of the worker's labour). The picture has become more complex though with so many other influences: ethical and moral responsibility to the worker, psychological status of the worker, impacts caused by the compensation process itself, the approach to policy development that is analogous to negotiated benefits, and legal culpability. The WCB began by helping workers with health related problems, and secondarily to helping to resolve the consequences of the health issue.

It is not appropriate to consider the two models, therapeutic and prevention, as mutually exclusive. It is quite realistic to suggest that the therapeutic model should have prevention as a major function. This is analogous to the concept of continuum of care which is integral to the health care reform efforts outside the WCB, in most provinces and regions. In the WCB, the term continuum of care is describing an internal program which is not the same as the health reform concept. Continuum of care external to the WCB describes the ability of a health organization to provide acute, chronic, rehabilitation, long term care, palliative care and prevention within its mandate. The concept is based upon two major ideas: patients should perceive a 'seamless' transfer between the above activities when it is required by them; and providers should have the ability to assign resources to the area most in need based upon a value across the whole spectrum of the system and link the ideas that come from each segment of care into a preventative plan. Using this comparison, the prevention principles can readily be incorporated into the therapeutic model. The converse is not necessarily true. In the prevention model, it is not required to have a major thrust in the area of therapy. However for reasons given below, it is recommended that the therapeutic model be reinforced, as the preeminent component.

Following the discussions of the preceding two paragraphs, the model that is being proposed in this document is a health related therapeutic model. In doing so, it is not adequate to move to a health model based upon the older version of acute intervention alone, or of a single discipline activity, or of the independent provider of the past, or of simply being reactive. The conclusions that follow address these issues and support a move to a therapeutic model in a modern format. Basing a system on health issues can and does lead to a modern organization, especially as the underlying purpose for the WCB has not changed. However, it is imperative, appropriate and correct to go back to the basics, and consider the positive gains of beginning with a therapeutic model and designing the system to respond to the underlying health issue. This paper does not complete the picture of how compensation issues, financial management, policy development or prevention issues need to be designed as a consequence of the focus on the therapeutic model, but some of that is obvious if one starts by saying "the worker is injured and has a problem with his/her health. What can I (my department or function) do to make that better". Then one must be accountable for that function.

There is evidence that the way compensation and legal issues are managed actually can have detrimental effects on the clinical outcomes\(^2\). If an activity such as claims processing by the WCB was contributing to the poor clinical care and outcome of the worker, is that appropriate?

In fact, the major underlying issue behind the Krever Commission into the blood supply in Canada is analogous to the above. Fault was found in the Red Cross for those decisions that seemed to ignore the underlying health reason for the establishment of the blood supply system, to contribute to the improved health of the patient by safe blood transfusions. It was ignored and decisions based on financial and resource management criteria led to viral infections (HIV and hepatitis C) in blood transfusion recipients. They forgot what they were created for, even though they had the information and skills to make a different decision.

Therefore, below is a list of issues related to the medical/clinical functions that are necessary to consider in support of a modern therapeutic model.
3.0 STRATEGIC ISSUES

It is interesting to review some of the evolution that has occurred in the WCB Mission and Vision Statements over the recent years. In 1991, the approved WCB Mission Statement was:

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

In a report released in 1996, the Vision Statement was:

Workers and Workplaces
Safe and Secure from Injury and Disease

In the same report, the Mission Statement read:

To Strengthen the trust of workers and employers
in the mutual insurance of safe workplaces with income
security and safe return to work for injured workers

It is interesting to interpret these changes in the context of the models above (section 2.0). It would appear that the 1991 vision statement gives the therapeutic model preeminence, whereas the 1996 gives a strong support for the prevention model. In fact, the Mission statement of the 1996 report indicates that 'insurance' is important based upon the recommendation of Meredith in 1913 that the model should be "practically a system of compulsory mutual insurance under the management of the state". Perhaps in reviewing these very important statements, it is obvious that clarity is lacking and it is hard for staff to know what aspects should be most emphasized.

The Mission and Vision statements of the Leslie R. Peterson Rehabilitation Centre are not entirely consistent with the WCB mission and vision statements, and therefore do not provide clear direction to all who are influenced by them.

The mission statement is:

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

The vision statement is:

We are North American leaders in returning injured workers to productive employment through rehabilitation. We do this by:

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

4 Transforming the Workers' Compensation Board of British Columbia: A Strategic Plan, 1996.
Traditionally the loyalty of a physician is to the welfare of his/her patients. However, as described above, the role of the medical group at the WCB is significantly ambiguous. The physicians have conflicting loyalties as influenced by the major functions of the WCB.

Historically, the workers’ compensation system had the appearance of an insurance company with a medical system “tacked on”. It is evolving in part through recent Board initiatives and will continue to evolve in response to the recommendations of the Royal Commission. Even though the workers’ compensation system in B.C. is evolving, history has left a negative imprint of the activities of the WCB physicians from individuals external to the Board. Clarification of the “business” of the WCB is critical to allow physicians, and others to understand their role in the organization and contribute productively and with commitment.

It is therefore critical that the mandate of the WCB be clarified, and further that a preeminence of one of the models — therapeutic, compensation or prevention — be decided upon. This report recommends that the therapeutic model be chosen.

**Conclusion 1. Clarify Strategic Vision:** The WCB should clarify its major mandate and the roles of each of the major groups and divisions within the organization. The importance of clinical care as embodied in the therapeutic model should be reinforced.

The fact that several different perceived mandates were voiced by staff interviewed suggests that the vision for the WCB is not clear, and must be shared by one and all at the Board. As one WCB physician mentioned, “it is so much easier to know what to do as we are getting a better idea of the big picture”. The critical nature of conclusion 1 cannot be underestimated. It is the overarching concept that brings staff together in a clear and consistent purpose. Furthermore, it would be an interesting and informative exercise to create scenarios such as the one in section 1.4 (perhaps with more complexities) to assess how different segments of the organization would approach such problems for resolution, and how the various groups could work together more. Problem solving is a very powerful team building and educational tool.

3.1 **Accountability**

Multiple reviews, reports and past Royal Commissions have outlined some of the problems and proposed solutions for various segments of the organization. However, one is left with the impression that these reviews have not always been acted upon or the suggestions implemented. There is a need for leaders and staff to be accountable for performance of their duties. The leaders particularly need to focus on strategic management, i.e., on the design and implementation of strategically important decisions, and ensure that operational issues are delegated to be managed at the level in the organization most appropriate to the problem.

Some of B.C.’s public service agencies are beginning to lean towards the Canadian Comprehensive Audit Foundation (CCAF) guidelines as an accountability framework. In discussions with members of the Auditor General’s Office on behalf of other agencies, there is good evidence that these guidelines can be successfully applied at the senior level. Given the recent review of the WCB by the Auditor General’s Office (which these authors found to be excellent) and the response from the WCB, it would be appropriate to consider the CCAF guidelines as the “accountability management tool” for the WCB. The guidelines should work well for the senior group but would need to be adapted for the various divisions and departments within the organization as not all of the 12 guidelines are applicable to each group. However, they would provide a consistent approach.

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5 Accountability Reporting Review by Auditor General of BC
6 Auditor General Accountability Recommendations — WCB Response to:
Recommendation 2. Utilize an Accountability Framework: The WCB Senior Executive Committee should adopt an accountability framework such as the CCAF guidelines as the management tool for monitoring accountability of the leadership group. The framework should be adapted to all other segments of the organization.
4.0 MAJOR ISSUES OF MEDICAL STRUCTURE AND FUNCTION

4.1 Medical Staff

In reviewing the activities at the WCB, it is apparent that there are strengths and weaknesses. There are several areas that demonstrate leadership by the WCB; e.g., establishing a clinic for chronic low back pain (and now for chronic pain); and their leadership in the use of a guideline for low back pain. The development of partnerships with community facilities and clinicians is an excellent program which requires monitoring to ensure quality care is being provided. It is also a superb mechanism to perform Province-wide benchmarking, i.e., identifying those health care providers that appear to be doing a better job than most, and then assessing what the differences are so every provider can improve. The continuum of care model provides a conceptual framework to enhance early return to work for injured workers\(^7\). Identification of the 'high risk cases' early as a proactive approach seems to be superior in clinical and return to work outcomes to one that is reactive. This continuum of care model provides a proactive opportunity for the development and implementation of the case management model (see section 5.1).

4.2 Transition

As one reviews the activities and documents at the WCB, one is left with the impression of a significant transition or evolution taking place at present. Clearly some of the impressions of the medical section are outdated. Nonetheless, these outdated concepts have left a perception with many external individuals that is not good and an internal functioning that is in need of change and upgrading. Many of the conclusions herein are in fact being considered currently. Nonetheless, there appear to be some unresolved issues that must be addressed in order to move forward.

4.3 Medical Staff Qualifications and Competence

During the review, much was stated and written concerning the qualifications and competence of the medical staff at the WCB. Perhaps there are several contributing factors to competence (registration, qualifications, education, skills required and competence in performing one's duties).

4.3.1 Registration and Qualifications

With respect to registration, there are two types of registration relevant to this discussion. The first is registration with the College of Physicians and Surgeons of British Columbia. It is required for all physicians, generalists or specialists, if they are to practise in the Province. The second registration is with the Royal College of Physicians and Surgeons of Canada. It is a College for Specialists only, for those who have taken four or more years past their M.D. degree. The latter specialists are called Fellows of the Royal College, and therefore have fellowship training. There is an intermediate level of training between generalists and specialists called certification, for those who have taken extra training, typically of one or two years past the M.D., and have received a certificate in a specific area of training.

In the past, there was one sentinel incident wherein a few physicians on the Medical Review Panel converted their registration in the College of Physicians and Surgeons of B.C. from active to inactive. They were retired from active practise and decided they did not require active registration in the College any longer. Some individuals in the lay public found that these physicians were not registered with the College, and hence assumed that they were not fully qualified M.D.’s. The College and the WCB does not feel that this is appropriate and hence now all physicians affiliated with the WCB have appropriate registration in the College of Physicians and Surgeons of B.C.

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\(^7\) Rehabilitation Network Performance Measures, Quarterly Management Meeting, March 1998
Although all physicians affiliated with the WCB are registered with the College of Physicians and Surgeons of British Columbia, their qualifications vary. The majority of physicians at the WCB are general practitioners. If one considers some of the 'advanced' qualifications of the physicians on staff, the vast majority are general practitioners with an interest in compensation medicine. Some have their certificates in Occupational Medicine but none of the employed staff have their fellowships from the Royal College of Physicians and Surgeons of Canada in Occupational Medicine. A few have fellowships in other specialty areas. Many of the physicians who consult for the WCB or attend clinics in the Rehabilitation Centre on a sessional basis have their fellowship qualifications.

4.3.2 Continuing Medical Education

From the interviews, there were apparently some WCB physicians in the past who viewed the WCB appointment as an opportunity to change careers, but some were not committed to the concept and principles of compensation medicine, or to learning actively about the area. This problem is much improved, including the contractual obligations for physicians to take continuing medical education courses\(^8\). It is not completely resolved however, but there are further conclusions below.

Although the new contract includes a requirement for continuing medical education, there is a feeling amongst some of the medical staff interviewed that education is not truly encouraged at the WCB. Some understood there to be a restriction on completing their continuing medical education outside of B.C. This is not an official policy however, and should be clarified. It is also not a policy to encourage if the physicians are expected to be experts in their fields.

Education must also involve learning from colleagues at the WCB. This would include appropriate feedback regarding management of cases, sharing of findings on literature reviews for specific injuries or diseases, active participation in teaching one another [such as regular medical rounds], active use of the Internet and medline searches, and attendance at leading national and international conferences at which some of the experiences of the WCB should be presented. Publication of research findings in peer reviewed journals should be encouraged. During this review, there was very little evidence of any of these types of activities.

Conclusion 3. Create a Learning Environment: Medical administration should promote a learning environment and learning expectation for WCB physicians. Physicians should be accountable for their continuing medical education, for sharing knowledge with other clinicians inside the WCB, and conversely, learning from other clinicians.

4.3.3 Future Planning of Medical Staff

There are several factors affecting the medical staff human resource needs for the WCB. They include:

- the possibility that the number of medical advisers will be decreased as a result of implementation of case management and the use of nurse advisers;
- approximately 50 percent of Board physicians are over 55 years of age;
- some physicians are over 65 years of age; and
- as there is a need to develop provincial leadership and to play a major role in the sharing and acquisition of knowledge (see below section 4.8), there is a strong probability that the quali-

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\(^8\) Salaried Physicians Agreement
fications and/or skill sets of the physicians employed in the future by the WCB will be different.

Determining the appropriate qualifications and skills begins with a clear understanding of the future plans of the WCB. With evolution to case management (see section 5.1), the addition of nurse advisors, the increased importance of research (see section 4.8), and the need for team oriented diagnostics and therapies, there will be a multitude of skills and qualifications required. These skill sets need to be identified. There was no evidence that this had been done. This aspect will be discussed again later in section 5.2.

Finding recruits that have the required skill sets may not be easy as individuals with advanced training and qualifications (for example, in Occupational Medicine, a recognized Fellowship Program in Canada and elsewhere) are rather rare, and in demand elsewhere.

During the interviews, another suggestion was made to design an educational curriculum relevant to compensation medicine which would identify and develop the skill set required to fit the needs of the WCB's medical division. In this context, compensation medicine is different from Occupational Medicine, in that it requires knowledge of general medicine, injury, occupational diseases and policy. Some we interviewed believed this to be a problem faced by similar organizations in other provinces. Given this is a common problem, there would be an opportunity, if not the need, for the various Workers' Compensation Boards across Canada perhaps working in conjunction with one or two Universities or Colleges, to coordinate a training program curriculum. It should not be implied that it would replace other training programs or fellowship programs but would be complementary. It could be utilized for the education of new recruits to the Boards. Also, existing certification programs could be approached to consider expanding their mandates to be more responsive to the needs of the Compensation Boards across the country.

The physicians' retirement age should be consistent with all other WCB employees at 65 years, unless the retirement would have a detrimental effect on specific skill sets or physician supply - that is, retirement at 65 is the rule, and only extended for exceptional circumstances based strictly upon the needs of the WCB.

Once a medical human resource plan is developed, special attention must be given to transition, to educate those that remain and/or to recruit those with the required skill sets. One suggestion to be given serious consideration is to support the training of one or more individuals (internal or external to the WCB) to return to the WCB once the requisite skills have been obtained.

Conclusion 4. Develop A Comprehensive Medical Human Resource Plan: The WCB should develop a comprehensive medical human resource plan. This should include:

- a more detailed assessment of the number and type of physicians required in the future as influenced by retirement and changing programs;
- a firm policy that the retirement age is 65 years unless there is a specific need of the WCB;
- a clear enunciation of the skill sets required by the WCB physicians especially given the probability of role change;
- a specific plan for the recruitment, retention and training of physicians in the WCB; and
• the description of a training program which would provide individuals with the knowledge and skills required (this could be in conjunction with other Workers' Compensation organizations across Canada).

4.3.4 Quality of Care and Evaluation

Registration and qualifications do not necessarily ensure good quality work. Directly evaluating the quality of care in this short review is not feasible so discussions were held with several individuals inside and outside of the WCB regarding their perception of the quality of the medical staff. One knowledgeable person interviewed wanted to complain about the quality of work of a specific physician but at the same time indicated that most of them seemed to be doing their jobs reasonably well. By interview, the internal evaluation mechanisms for the quality of care provided by physicians at the WCB were described as "rudimentary". Feedback regarding patient management, claims assessment, appeals outcomes, etc., is not well utilized, nor is a learning environment model (see above conclusion 3). Board physicians tend to work in isolation as per the quote "I don't see much of how a colleague would handle such a case". Job descriptions have been updated recently with a clearer indication of responsibilities. Accountability must be understood. Performance evaluations are not regularly done nor are they reflective of the responsibilities of the staff.

Conclusion 5. Develop Medical Responsibilities, Accountabilities and Regular Evaluation Mechanisms: That the WCB develop clear responsibilities and accountabilities for the various medical positions (job descriptions and performance evaluations). The major functions of the positions must be consistent with the mandate of the organization. The performance evaluation mechanism should include measures of "customer input", measurable outcomes and clear evidence of ongoing commitment to a learning environment.

One must ensure that the job descriptions and performance evaluations do not become an end unto themselves and do not contribute to the "bureaucracy" of the human resource management of physicians. It is critical that the WCB develop an evaluation program which is supportive, educational and enlightening. We are aware that efforts at medical staff evaluations in other health care institutions have become excessively bureaucratic.

4.4 External Relationships of WCB Physicians with Outside Physicians

Perhaps one of the most critical issues is the perceived poor credibility of the WCB physicians by external physicians. This is an issue that may be embedded in history, in communication gaps, and in lack of clarity of the role of the WCB and its physicians. Perhaps one of the best descriptions of the relationship with outside family physicians was the quote "distant but not totally dissatisfactory". Physicians in general practice tend not to refer patients to the WCB physicians (there are exceptions of course) as there is seemingly a low respect by the general practitioner of the WCB physician.

WCB physicians are seen "to be guided more by insurance company policies than by the Hippocratic Oath", a quote by a physician. External to the WCB, physicians perceive the WCB medical staff to be 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 opinion presenting both pros and cons of a claim. This leaves the perception of an inherent bias by the WCB physician that is "anti-worker". This is magnified when the medical staff overrule the recommendations of outside family physicians or specialists, often based on what appears to be either inadequate information or due to policy restrictions.

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9 Medical Advisors Position Guide
Some also claim that the WCB physicians are not as current as they should be, in providing advice and information that is at the leading edge of their field.

WCB physicians feel their relationship with general practitioners is reasonable, that in reality there is usually very little debate about the underlying medical condition but there can be problems of communication and occasional conflict.

Therefore, there appears to be a significant credibility problem for the physicians within the WCB, and the possibility that they themselves do not appreciate the importance or depth of this feeling. In order to begin addressing this, it is recommended that clear understandings of the role of the WCB and the attending physicians be established and published regularly. Tables 2 and 3 list some of the basics roles of the WCB physician and the attending physician respectively.

**TABLE 2**

**ROLE OF THE WCB PHYSICIAN**

<table>
<thead>
<tr>
<th>Role of WCB Physician</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>he/she should focus his/her primary attention on the clinical aspects of each case</td>
<td></td>
</tr>
<tr>
<td>he/she should be knowledgeable of the components of a fair decision, namely</td>
<td>1. complete a full investigation and be knowledgeable of the facts, 2. understand the current medical literature relevant to the case, and 3. be unbiased</td>
</tr>
<tr>
<td>he/she should present a balanced picture with respect to the claim providing evidence for and against the support of the claim and an impartial medical opinion</td>
<td></td>
</tr>
<tr>
<td>he/she should support the attending physician with whatever information can be provided concerning the background literature relevant to the case, information regarding best practices with respect to treatment, anticipated milestones of the treatment, resources available and what to do if those outcomes and timelines are not met</td>
<td></td>
</tr>
<tr>
<td>he/she should acknowledge the contribution of members of other professions in treatment of patients, and utilize whatever evidence based information is available to judge appropriate access of patients to other professions. Case management will enhance the interdependence of multidisciplinary input and physicians must be committed to be part of a team approach to patient care</td>
<td></td>
</tr>
<tr>
<td>he/she should directly contact either the patient (recommended) or the attending physician if the history is uncertain or if the claim is likely to be turned down (See section 4.5, 4.6 and conclusion 8 below)</td>
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</tbody>
</table>
Conclusion 6. Clarify and Publicize Role of WCB and Attending Physicians: The WCB should clarify the role of the WCB physician and the attending physician to include the points outlined in tables 2 and 3, and ensure they are appropriately and regularly communicated. Enhanced contact between the WCB and attending physicians will be the basis for improved credibility and secure collegial relationships. Significant effort must be made by the WCB physicians to make this contact in a manner outlined.

A corollary derives from this particular discussion. There is a strong belief in the community outside the WCB that the WCB physician per se decides upon a claim. In fact some inside the WCB also believe that the physician plays too large a role in adjudication, compared to what the design was intended to do. This impression is based upon the observation that the adjudicator often accepts an opinion of the physician as the recommendation. This relationship is not really surprising in an environment of review teams who need to work together collaboratively, where the physician or the other team members cannot be considered to be truly independent. It is also true that the power and authority of the physician may be considerable in claims adjudication. Therefore, it is critical that the WCB physician presents a comprehensive, fair and unbiased opinion. The adjudication of claims may evolve into a different process with the initiation of case management and the introduction of the nurse advisor. Nonetheless, the power to influence the outcome from the physicians must be acknowledged. It would be preferable to recognize this power and authority by reinforcing the extreme importance of impartial opinions based upon principles of fair decisions (see Table 2 above).

4.5 Relationship of WCB Physicians with Patients

There were many submissions at the Hearings for the Royal Commission from injured workers (many were read during this review). They often stated that the WCB physicians have a pivotal role in the approval or rejection of a claim, that they were very frustrated with the medical staff when decisions were made without the medical staff actually seeing the patient directly, and that they had a very poor impression of the WCB physician staff.

**TABLE 3**

**ROLE OF THE ATTENDING PHYSICIAN**

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>be the major player in the diagnosis and treatment of the work related injury or occupational disease (supported by WCB physicians)</td>
<td></td>
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<tr>
<td>indicate honestly to their patients if they believe the WCB claim is not likely to be accepted (no accurate data is available but there were several individuals who estimated that the number of inappropriately approved claims was about equivalent to the number of inappropriately dismissed ones)</td>
<td></td>
</tr>
<tr>
<td>fill in the forms accurately to present a comprehensive and unbiased opinion of the particular claim history. This would ensure that inappropriate approval of claims is minimized, and this accountability rests largely with the attending physician</td>
<td></td>
</tr>
<tr>
<td>only after a claim is rejected should the attending physician become an advocate for the worker, and only then if the attending physician truly believes that the claim is inappropriately rejected. Use of the term advocacy here does not refer to the advocacy role that family/attending physicians play in the normal routine diagnosis and treatment of their patients. However, advocacy should not play a role in the routine claims submission. Advocacy should only occur if there is a belief that an incorrect decision has been reached.</td>
<td></td>
</tr>
</tbody>
</table>
On the other hand, the WCB physicians feel that their major role is to provide interpretation of the probable causative nature of the occupational disease or injury, not necessarily additional insight into the diagnosis or therapy. There is rarely debate between the attending and WCB physicians about the underlying diagnosis and the general approach to therapy, which is usually provided by the attending physician. Many cases were cited though wherein the WCB physician was able to make a diagnosis missed by the attending physician. Causation can be a different issue though. It is established using the history of the incident/illness, an understanding of the pathophysiology of the incident/illness, and understanding relevant work site ergonomics often without examining the patient directly. However, inherent in this argument is the need to ensure that the history is complete and accurate. It is recognized by many WCB staff that some incorrect decisions are made based on incomplete information or misunderstandings of events leading up to the incident, but there has been no organized, evaluation of this. The Board physician should be prepared to request or obtain an accurate comprehensive history. This should involve direct discussions with the patient as needed. (See conclusion 8).

Therefore, there is again a need to clarify the role of the team members and communicate it properly amongst team members, and with the patient. It must be remembered that the patient is a member of the treatment team, and as such has specific responsibilities to perform to ensure a quality outcome. Considering the relative responsibilities of the team members is particularly timely as the WCB moves to case management. The role of the WCB physician (Table 2, in part) and other team members including the patient, must be reinforced. The physician must be actively involved in obtaining a comprehensive history (or backing up the nurse advisor when appropriate). The role of the attending physician should also be clearly stated. It should be understood from whom the patient will receive telephone calls, will get treatment advice, will receive assistance on medical aids, etc. The patient will then become a more active member of the treatment team, and will be better able to understand and respond to the rehabilitation team. Given the initiation of case management, it is a very appropriate time to clarify these roles, and to make it known to injured workers who enter into the case management care.

Conclusion 7. Clarify and Publicize the Role of Treatment Team Members: The WCB should clarify the role of the members of the treatment team, including the patient, in case management. This information should be provided to every patient entering the case management care model.

Conclusion 8. Encourage Contact Between WCB Physicians and Patients: The WCB physicians should be active participants in direct contact with patients/workers especially in claims likely to be, or which are, in fact, rejected. This direct contact should be either in an office setting or via telephone. It should however not be outside the defined role of the WCB physicians.

4.6 Appeals Process

The appeals mechanism deserves some discussion, at least the Medical Review Panel component. An appeal process is necessary within the system. Although in excess of 95 percent of the claims are approved without problems, a small number give rise to a large amount of appeal related work. Furthermore, with respect to the medically related compensation issues, there is evidence that many of the appeals are judged in favour of the worker with approximately 50 percent being overturned at the Medical Review Panel level. This is analogous to a quality assurance system which is focused on detecting problems after the adjudication process is completed, and "correcting" them after the fact. If one utilized a quality improvement perspective ["do it right the first time"] during the adjudication process per se, one would try to focus more on finding a fair and accurate adjudication of a claim and decrease the need for an appeal.
At the Medical Review Panel, there are stated to be two major reasons for the adjudicated decision to be overturned: the accuracy of the data and history which pertains to the incident involved; or a judgment which is in a clinical "grey area".

Sometimes rejected claims are approved by the Medical Review Panel due to inadequate or partial information with respect to the history of the accident or occupational disease. The true skill set of the WCB physician should be in assessing the complete history relevant to the case and to ensure that it is available when the decision is to be made. It is probable that a similar activity could be provided by the nurse advisor, but at times a Medical Advisor would be better to do this. The patient and the attending physician would be more appreciative of the direct attempt to help. (This latter aspect could be considered a potential conflict of interest if the WCB physician is to assist in the adjudication of claims. It is our conclusion that the physician should be perceived first and foremost as assisting in rehabilitation and not as a gatekeeper.)

Overturning a decision in a "grey area" begs the question if information presented or decisions are biased against the injured worker. The relevant data should be analyzed. It is usually not a question of diagnosis but whether the problem was caused by work \textit{per se}, or whether work exacerbated a genetic predisposition or a degenerative change. One suggestion was that partial compensation should be considered here (we have not reviewed the problem to reach a conclusion on this suggestion).

However the biggest complaint that comes to the Medical Review Panel is that the Board physician turned down the claim without even examining the patient. This is a major issue on behalf of the worker at least as presented at the Hearings. It could be that this factor, the lack of direct contact with the patient, is a major predisposing factor in the generation of appeals. [This contention can be assessed in a future evidence-based study.]

Conclusion 9. Analyze Appeals Outcomes: Analyze the outcomes of the Medical Review Panel, and possibly other appeal decisions, to determine the reasons for overturning the decision, to assess what could have been done differently in the early adjudication phase, to assess if adjudications are in any way biased, and improve on the processing of claims, at least in the context of the medical/clinical input.

Conclusion 8 (repeated from above). Encourage Contact Between WCB Physicians and Patients: The WCB physicians should be active participants in direct contact with patients/workers especially in claims likely to be, or which are, in fact, rejected. This direct contact should be either in an office setting or via phone. It should however not be outside the defined role of the WCB physicians.

4.7 Policy Development

The process of policy development and policy change appears inappropriate. This was not a major thrust of this particular review, but it became apparent that several different groups had several different theories about how policy development should occur. Some proposed that policies: should be generated on a precedent setting approach [analogous to typical legal precedent setting cases]; should be established only by the Panel of the WCB; or, should be established by the knowledgable and accurate interpretation of evidence.

Some believed that policies were restrictive whereas others felt that policies were inaccurate and inappropriate. There is no question that there are inconsistencies in the existing medical policies [see table 4 below]. For example, with lead exposure but no clinical disease, the WCB can ask the employee and employer to stop the exposure because clinical disease may occur. But unless there is disease, there
is no compensation; i.e., the employer is responsible for all preventative actions. With TB exposure, compensation can only be considered if there is a recent change in the TB skin test, meaning that an earlier test result must have been tested and negative. There are some medically dubious benefits such as the presumption that compensation is appropriate for all heart attacks amongst firefighters. If the heart attack is related to fighting a fire, then it may make sense but other conditions such as diabetes or sedentary life style and predisposing activities other than fighting a fire, like shovelling snow, should be considered. These inconsistencies or inaccuracies tend to frustrate the WCB medical staff who may wish to give a medical opinion rather than one that is given in Schedule B, the list of compensatable injuries and diseases. From the external perspective these inconsistencies risk making a "mockery" of the WCB medical policies, and some found the policies inconsistent.

TABLE 4
EXPOSURES OR INJURIES THAT QUALIFY FOR COMPENSATION

<table>
<thead>
<tr>
<th>AGENT</th>
<th>EXPOSURE BUT NO INJURY</th>
<th>EXPOSURE VIA INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>TB</td>
<td>no, without skin test conversion to positive</td>
<td>n/a</td>
</tr>
<tr>
<td>Lead</td>
<td>no compensation without clinical disease but must stop the exposure or disease may occur</td>
<td>n/a</td>
</tr>
</tbody>
</table>

It is as if the policy development is a negotiated benefit, not a 'truism' about what is right to compensate in a workplace injury or occupational disease. As one person interviewed stated, with the existing mechanism for policy development, "there is one consistent outcome, namely that there is either a winner or loser but not two winners".

Conclusion 10. Address Policy Development: The WCB should review the medical policies in place to determine if they are consistent with current clinical knowledge, and consistent with one another. A mechanism for bringing forward inconsistent policies must be established.

4.8 Provincial and National Leadership — Knowledge Based Service Industry

Many one of a kind organizations in British Columbia act as a resource for the whole Province. Examples in the health care realm include Vancouver Hospital and Health Science Centre, British Columbia's Children's Hospital, B.C. Women's, and the B.C. Cancer Agency. In performing this "provincial responsibility", the organizations provide education, information, support, indirect clinical care via other health care providers scattered throughout the province and direct clinical care. The organization providing the provincial leadership must be knowledgeable, able to provide information on the best standards of care currently available, be able to measure and evaluate the care that is occurring elsewhere in the Province, be willing to utilize, assess and improve standard approaches to care, see complex patients, and be credible.

As discussed previously, some of these activities are occurring in the WCB but not all, and not in a coordinated manner. There are some good examples of this type of leadership. The Worker's Compensation Board through the Prevention Division and the posters and pamphlets department does a good job of promoting health and safety in the workplace. The pamphlet "Back Talk" for example has been borrowed by compensation agencies around the world. The physicians at the Leslie Peterson Research
Centre are currently involved in a multi-centre research study. These initiatives should continue to be encouraged.

Perhaps the major question to be asked is, why should the WCB assume a Provincial leadership role? The statement "World leadership is our goal" is part of the 1991 mission statement and the Rehabilitation Centre strives to be "North American leaders" (see section 3.0). Therefore there are some in the WCB who believe that it is of critical importance. There are numerous criteria that could be supportive of such an approach but we will discuss the Provincial leadership role first before the World leadership one. As described above, the clinical care system is highly dependent on the efforts of the attending physicians in the community. They have variable knowledge of care of the injured worker, and consequently variable practises, and therefore, presumably variable outcomes and variable resource utilization. Some group must manage that variability and provide standards that achieve quality of care and efficiency. Furthermore, there are no recognized leaders in assessing the trends, patterns, or changes in clinical care throughout the Province and the WCB is well suited to do this. This factor is especially important now that over 60 partners are providing care to the injured worker, and results must be monitored. If leadership is achieved at the Provincial level, others nationally and internationally will notice and the World leadership role will be closer at hand.

There is a great opportunity for the WCB to strive for a provincial leadership role with respect to clinical care, clinical investigations, clinical standards of practice and clinical improvements in quality of care. As a 'virtual monopoly' with a large number of patients to deal with and to learn from, the WCB is uniquely positioned to provide such a service to the total Province. The number and severity of work related injuries, occupational diseases and deaths in the work environment require some organization to take this leadership role and the WCB is best positioned to do so.

There are several preconditions necessary for achieving success as a provincial leader in workers' compensation. These include the willingness to incorporate the concept fully into the WCB mandate, the present poor credibility of the WCB as a clinical leader, the availability and use of standard therapeutic protocols (best practises) for common injuries or occupational diseases, and the ability to collect clinically relevant data and assess that data for clinical improvement. Each of these potential obstructions must be addressed in order to proceed fully and effectively with Provincial leadership. Acceptance of this mandate would imply some changes, most of which are addressed within this review.

**Conclusion 11. Enhance the Provincial Leadership Role: The WCB should actively pursue the leadership role inherent in a mandate that includes Provincial leadership in care of the worker with injury or disease.**

A corollary of this conclusion is acknowledging the importance of "knowledge" in achieving this success. Knowledge must be current, relevant, retrieved from the patient population being served, shared with the providers, and able to reflect clinical interventions and clinical outcomes over a long term period. This would imply a commitment to education, learning, research and objective standards of care. Each of these commitments would have significant benefits for the WCB and potentially result in profound improvement for the health of the patient population being served, i.e. in the prevention and improved treatment of work related injuries, deaths and occupational diseases. Again the WCB is active in some of these areas but not in others, and a commitment to excel has not been present, at least historically. For instance, building upon the statement earlier in this paragraph, the WCB: is thought by some not to be current although the information that is shared is usually relevant; does not retrieve good clinical outcome data from their patient populations; does a mediocre job in sharing the information with clinicians and other providers; and, cannot track clinical interventions or outcomes over long periods of time.

The purpose and outcome of research must be discussed. Perhaps the most important reason to have an active research program is to assess what the specific problems are that lead to work related injuries and occupational diseases within B.C. B.C. has an injury rate approximately twice that of
Ontario. Why? It is not really known although people mention different reporting mechanisms and a different industrial base as reasons. Furthermore, it doesn't seem to be getting better. Why? These problems are hard to correct when the cause is not known and understood. But what if it is true? The impact of correcting them would be tremendous.

Research does have other benefits, some of which can be objectively measured and others which are less tangible. If staff are recruited into an environment where research is expected, supported and accountable, there is a milieu that enhances both the clinical care and knowledge base. The clinical care is improved because the individuals who are there are expected to be current in their knowledge and to provide the best and most up to date information to the providers that they serve provincially. If the staff is not current, there is negative impact on the treatment of the injured worker and the credibility of the organization. The leading researchers are often the leading clinicians for the most complex cases. If research is not supported or respected, then typically those who are true leaders in their field are sought after by other agencies and often recruited away (this is definitely an observable pattern at the Institutions listed in the first paragraph of this section, 4.8). Therefore, research becomes a retention issue for those individuals of provincial and national leadership qualities. Those staff members who do not contribute to the knowledge base are not perceived to be recruitment material by other agencies, and therefore stay. The organization can then become 'populated by mediocrity'.

Research is, in part, an attitude requiring communication and cooperation with other leaders in the field. Both Alberta and Ontario have developed research thrusts with various affiliations with their respective Universities, of Alberta or of Toronto. In Toronto, an independent research agency, the Institute of Work and Health has been created, and in both Alberta and Ontario, the term of these trial initiatives was five years. Interactions with other provinces and agencies such as the Institute for Work and Health or the U of A initiative are critical. Collaboration will ensure that duplication is not excessive and that advances in one organization can be incorporated into the practices of another. There must be communication between agencies in order to reinforce the expectation of maintaining current standards of care, an issue of credibility. Collaboration inside B.C. is also relevant with the expertise available at UBC and other agencies. Furthermore, WCB staff committed to research would also want to have a cross appointment to UBC to maintain an academical link.

**Conclusion 12. Establish/Enhance a Clinical Research Mandate: The WCB should make a commitment to research for the acquisition of new knowledge into the causes, treatment and prevention of work related injuries and occupational diseases in British Columbia.**

4.9 Guidelines

Perhaps one should ask whether guidelines are useful. Much of the literature implies that adherence to guidelines improves the quality of care and the efficiency of utilization of resources. WCB physicians have stated during the interviews that community physicians often do not have well coordinated or planned approaches to care for the injured worker, thereby leading to inefficiencies in care and probably differences in outcome. Given a desire to achieve a consistency of approach and an economy of resource utilization while providing guidance for attending physicians based upon evidence, there would be a need for the use, evaluation and improvement of clinical practice guidelines for work related injuries.

The WCB is a good candidate for the use of guidelines based upon two major findings: the clinically complex cases will now be detected via the continuum of care model and referred proactively to

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10 In this discussion, the term guideline is used generically to refer to clinical practise guidelines, clinical practise plans, protocols, pathways or algorithms, all of which in some way follow the flow of patient information, clinical care activities and anticipated or unexpected outcomes as part of the guidance for the clinicians involved in the patient care. The other terms listed above refer to slightly techniques and tools that are often utilized in specific situations. The use of the word 'guideline' here is not meant to pre-empt the use of any of these tools in the appropriate time or place.
the case management program for entry into a guideline; and there are only a few major diagnoses that account for a large portion of the cases involved. In the continuum of care, the first 75% of the claims should be resolved within the first four weeks\(^\text{11}\). The remaining 25% plus those that have major risk factors such as significant clinical injury, etc., will then be referred to the case management model. (See Section 5.1 for more details on the case management model). For instance, in the first year of trial of case management at Prince George, 4 types of injuries, fractures (47%), low back pain (26%), and knee (8%) and shoulders (8%) injuries accounted for 88% of the 171 claims in which the medical advisor was involved. The important point being that the ability to focus on relatively few diagnoses (although there will likely be subsets within these categories) allows for the establishment of a standard approach and standard milestones for the vast majority of the cases.

The WCB is utilizing guidelines to a certain extent. For instance, they provide information to the attending physicians on low back pain, neck (cervical) pain, miniscal tears, Carpal Tunnel syndrome, and epicondylitis. Although this is a good start, in comparison, Washington State Workers' Compensation utilizes 13 different guidelines which include the above plus many others\(^\text{12}\). An interesting finding is that it took Washington 6 years to design these guidelines. The BC WCB must recognize the time taken to develop their own, but the Washington ones are a good place to start and are available over the Internet.

However, once the commitment is made to provide standard guidelines, then there are problems of design, dissemination, use and monitoring of the guidelines. It is a very complex issue as one must acknowledge several clinical and political truths. From a clinical perspective, one very knowledgeable interviewee said there are relatively few truly evidence based guidelines in rehabilitation medicine and there are very few clinicians who depend upon guidelines for an approach to a clinical problem. However, one must acknowledge that the use of guidelines that provide a standard approach to care also form the basis for the collection of evidence, and hence subsequent improvement of the quality of care. From a political perspective, it is well known that guidelines raise the anxiety and anger of many clinicians due to the concepts of "cookbook medicine" and "big brother is watching". Each of these concerns implies that there is a need to address guidelines in a very cautious and planned manner. There are approaches to the development, use, and monitoring of guidelines, some more successful than others\(^\text{13}\).

It is critical however to consider the guideline as a clinical trial template, which should be assessed and modified to improve the clinical care outcomes over time. Guidelines act as clinical investigation protocols that can be modified to assess different therapies, etc.. Therefore, guidelines must be, to a certain extent dynamic, and in constant need of improvement and upgrading. The clinical outcomes must be known and recorded, something that is not occurring at the present. Given this approach, the WCB physicians can provide leadership in designing and teaching the correct way to care for specific illnesses, and determine early when milestones are not being achieved.

One must consider further the use of guidelines as clinical investigative tools. Experts in rehabilitation medicine state that there is very little solid evidence regarding specific therapeutic approaches\(^\text{14}\) (and from interviews). In fact, some of the strong support for early intervention after injury, which is pushing the design of programs at the WCB, is debated in the literature\(^\text{14}\). Clearly, by following the clinical outcomes, by monitoring guideline use, and by utilizing guidelines to ask questions, the knowledge of what works and what doesn't can be gathered. (See also the discussion of research below).

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11 Rehabilitation Network Performance Measures, Quarterly Management Meeting, March 1998
12 Medical Treatment Guidelines in Washington Workers' Compensation (G Franklin, R Plaeger-Brockway), Available on the Internet from Washington State Department of Labor and Industries.
Another issue relates to the physicians in the community. There are a few, less than 5%, who account for about 50% of the WCB clinical activity by generalist practitioners. If they were following a standard approach, a large number of patients would receive the same care. These physicians should be very involved with the monitoring and analysis of the guideline derived data. Conversely, there are a large number of community physicians who handle a small number of claims each, but account for a large amount of clinical care in total. This latter group needs a different kind of approach to the dissemination and use of guidelines — "just in time" guidelines provision. These are quite different challenges to the education of the attending physicians.

Finally, the loop must be closed. Guidelines must be analyzed, and data provided back to the physicians involved. They must know the outcomes of their care activities, as the feedback is a powerful educational and change management tool to physicians. It is not the only tool, and others, more directive, may be required in the future to achieve full compliance with standards of care.

Conclusion 13. Utilize Clinical Guidelines: The WCB should enhance their commitment to the use of objective standards of care or guidelines\(^{15}\) in managing the injured worker. Efforts will be required to ensure that the guidelines are appropriately followed by the attending physician, and that they continually be improved, based upon clinically relevant evidence which is appropriately provided to the clinicians involved.

4.10 Performance Indicators

Some comments need to be made regarding performance indicators. Performance indicators should demonstrate if established goals are being achieved or if there are variations from those goals. Some can be derived from the accountability framework, as discussed above in section 3.1 and conclusion 2. Given there is a clinical component to the mandate for the WCB, then there should be clinically relevant performance indicators recorded on a regular basis. Although one applauds the concept of the continuum of care and the relationship to the external partners, the performance indicators chosen for those particular efforts illustrate how little clinically relevant information is being kept. The performance indicators being utilized in the recent review for the provider partners are shown in Table 5.

<table>
<thead>
<tr>
<th>KEY PERFORMANCE INDICATORS</th>
<th>OTHER PERFORMANCE MEASURES</th>
</tr>
</thead>
<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 or drugs for the pain. These are just two examples to illustrate that the performance indicators being utilized in the recent review for the provider partners are shown in Table 5.

\(^{15}\) In this discussion, the term guideline is used generically to refer to clinical practice guidelines, clinical practice plans, protocols, pathways or algorithms, all of which in some way follow the flow of patient information, clinical care activities and anticipated or unexpected outcomes as part of the guidance for the clinicians involved in the patient care. The other terms listed above refer to slightly techniques and tools that are often utilized in specific situations. The use of the word 'guideline' here is not meant to pre-empt the use of any of these tools in the appropriate time or place.
indicators chosen to date are clearly oriented towards utilization and costs with only one measure, client satisfaction, which could be related to clinical outcomes.

In the report\(^{16}\), prepared for the Panel of Administrators in 1997 on key indicators, the observation is just as acute. The Macro indicator entitled 'Nature and Financial Impact of Injuries" contains two measures, the duration of the STD claim and the conversion rate from STD to LTD. Neither of these indicators has anything to do with the nature of the injury, although it may pertain to the nature of the claim. In that document there are very few clinically relevant performance indicators, such as: what is the most common injury, or cause of death? Which industries are at risk for which injuries? What injuries tend to become more complex with respect to meeting the anticipated milestones during therapy? Many more questions can be asked.

Discussion of performance indicators is purposely addressed between the two sections, guidelines above and information systems below. Performance indicators are often derived from guidelines in response to how well individual patients are responding to the guidelines. That is, guideline measures often are excellent precursors of performance indicators. If these are chosen as performance indicators by those interested in the clinical outcomes, then the design of the information system must be responsive to follow those data and subsequently analyze it.

\textbf{Conclusion 14. Utilize Clinically Relevant Performance Indicators:} Clinically relevant performance indicators, not just indirectly related financial or utilization indicators, should be developed. An excellent (but not exclusive) source of good clinical performance indicators are the key measures from the guidelines used to monitor the clinical progress of the injured workers.

\textbf{4.11 Information Systems Relevant to Clinical Care}

In order to make any significant progress in the clinical problems facing the WCB, there is a tremendous need for clinical information. The ability to address clinical problems requires an ability to extract relevant data in response to specific clinical questions or hypotheses. In the review of medical administration of the WCB, 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 the financial management but these are not terribly useful for the clinical questions that need to be asked.

Perhaps the major observation relevant to this section is that there is virtually no clinically relevant information system established or operational. It was also said that the design for a clinical system is not comprehensive nor reflective of the needs of the clinical mandate of the WCB. Although some pseudo-clinical systems are in the planning stages, for example, the e-file system, the program to compare providers practise patterns, and fraud, the clinical Information System design is incomplete, and the present proposal could be considered a piecemeal solution. A new injury specific risk data system from MIRA in Massachusetts bears some promise, but it must be considered as a component of a comprehensive clinical Information System design, not the total package.

One initiative that has been started recently, and which should be encouraged to continue, is the integration of the WCB databases (about 7 or 8 separate ones) into the large integrated database project at UBC. This project previously had obtained data regarding Vital Statistics, MSP billing, Hospital admission, pharmacare (plan A - over 65) and continuing care, and to which the WCB data is now being added. This initiative will provide an opportunity to integrate the WCB databases themselves, as well as look at the impact of some of the WCB activities on non-WCB health care, and vice versa; for instance,\(^{16}\)

do many of the WCB patients get put onto non-WCB care after a claim is denied. It must be better utilized by WCB staff to ask questions that can only be answered using large integrated systems. With proper management of the confidentiality issues (apparently now in place), this should continue. Preliminary analysis of the data in the spring of 1998 has suggested some very important issues that need to be addressed.

Given that clinical care is a major component of the mandate, and that enhanced Provincial leadership is expected, then clinical information is required (also see above section 4.8, Provincial and National Leadership - Knowledge Based Service Industry). Clearly, the most obvious question relates to clinical outcomes. In fact, by assessing outcomes one can relate that back to the therapeutic interventions that were provided and finally relate those interventions back to the indicators that were utilized to decide upon the therapeutic intervention. From a simplistic point of view, there will be some outcomes that are good and others that are poor. For the poor outcomes, one can assess potentially inappropriate interventions and hence reassess the indicators for specific interventions and be more selective at the outset. It is the basis of continuous quality improvement.

The use of quality of life or functionality measures should be considered for routine use for individuals 'admitted' into the WCB system. Use of these measures, such as SF36 questionnaires, could provide baseline functional assessments after the injury as occurred, and at subsequent time periods during therapy. Questions could then be asked regarding specific injuries, specific therapies, or specific populations and work groups. SF36 is designed to be utilized in a primary care setting, which is the major therapeutic route for the injured worker.

In evaluating clinical outcomes, one must ask questions relevant to a specific population. The population basis for questions should not be claims related but rather be related to the industry of the worker, injury type, age, gender, therapeutic intervention, psychosocial factors, etc. The analysis should be guided by specific questions or hypotheses. If one designed questions relevant to the clinical realm early in the Information System design phase, one could have some idea of the type of information that should be collected. For instance:

- Which of the different partners utilize different techniques and have different clinical outcomes?
- What happens to the injured worker in the long term? Does he continue to require pain medication? Is there any residual problem from the injury? Is there a transference of his clinical care to MSP or even to social services?
- Are there specific types of injuries that have a low rate of successful therapies that require specific attention? Are they a specific focus for the next prevention initiative?
- Do the attending physicians utilize different approaches to the same problem, and if so, which ones are more successful? Which ones are less expensive?

Sometimes, the ability to link to other data bases is important. For instance, understanding preexisting conditions might be relevant information for the WCB. Preexisting conditions can and should be treated in the Ministry of Health supported clinical care system whereas the injury should be the responsibility of the WCB. Coordination of this data is likely required in order to fully understand the additional information that could be extracted in such linked databases.

A detailed review of the planned information system was not possible during the time available for this review. However, the reviewers have the very strong feeling that a clinically relevant database based upon clinically relevant questions within clinically relevant populations of workers has not been adequately designed. A comprehensive Information System plan for clinical care is required, not a piecemeal approach to specific functions or problems.
Conclusion 15. Complete the Design of a Clinical Information System: The design of an information system relevant to the clinical needs of the WCB should be completed using a clear "systems thinking" approach to the clinical mandate.\textsuperscript{17}

Conclusion 16. Continue with the Integrated Database Project: The WCB should continue to submit data to the large UBC-based data integration project, and become active users of the information for their own questions.

4.12 Funding Issues for Physicians

With respect to funding of physicians, there appear to be three major components to assess: the salaries for the WCB physicians, fee for service based upon Medical Services Plan (MSP) codes, and fee for service based upon WCB unique codes. There is also some important information arising from the distribution of physician fees with respect to WCB activities.

4.12.1 WCB Physician Salaries

The first component relates to the level of payment of the physician employed at WCB. It is mainly an issue of equity with other workers' compensation physicians in other provinces, and to a lesser extent, the comparative income within B.C. Some of the WCB physicians have remarked on the inadequacy of the salary level. There are other aspects of remuneration such as roles and responsibilities, seniority and performance.

Conclusion 17. Review WCB Physicians Salaries: The Human Resources Department at WCB should review the physicians' remuneration packages provided by workers' compensation boards across Canada and incomes of similarly qualified B.C. physicians to ensure equity. A reward system for salary should be developed which is aligned to the mandate and expectations of the WCB. The salary levels from other sources in the Province and across Canada should be communicated to the Medical Staff.

With respect to the fee for service agreement with physicians outside the WCB, there are two major components: MSP type and WCB unique fees items.

4.12.2 MSP Fee For Service Type

One component of fees for outside physicians is based upon MSP fees for activities recognized by the MSP. For many years, this system has provided an extra 4\% above the MSP rate equivalent to the benefits which are provided at approximately 4\% in the MSP agreement with the BCMA. Recently another 2\% was added to the contract to enhance the expectation of electronic billing and electronic report submission. The impact of these extra percentages is minimal on the average physician outside WCB 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 WCB work is the beginning of a two-tiered system (however, the more important source of this concern is discussed in the next section, 4.12.3). Some of the issues and problems between the WCB, Ministry of Health and BCMA should be resolved by tripartite discussions. In fact, all three parties should be part of the negotiations to ensure there is a consis-

tency across the Province. Furthermore, the Ministry of Health has some concerns with respect to the management of these "extra percentages" (4% and 2%) and its electronic billing system. The 4% benefits component should be transferred to the benefits component within the MSP and allow the WCB fee for service component to be allowable for benefits in the existing agreement between the Ministry of Health and BCMA. The 2% component of the supplement should be time limited and be removed within a reasonable period as technology transfers are successful.

Conclusion 18. Reallocate the Additional MSP-based Increment to the Benefits Pool within the MSP: The Ministry of Health, BCMA and WCB should meet to discuss the transference of the 4% increment into the benefits component supplied within MSP and to allow the WCB fee for service component to qualify for benefits in the existing MSP agreement. The additional 2% should be reassessed annually based upon whether the electronic billing and reports are being utilized, and should ultimately be withdrawn.

Conclusion 19. Negotiate Future Contracts with the Ministry of Health and the BCMA: Serious consideration should be given to have all future negotiations pertaining to this contract handled in a tripartite manner to ensure consistency and equitability across the multiple physician related contracts in the Province.

4.12.3 Fee for Service Items Unique to the WCB

The third component are those fees that the WCB recognizes uniquely which 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. But it is particularly 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 an amount 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. Is early intervention an effective approach? It would seem to be. Would decreasing the payment imply that all individuals wait longer than is clinically appropriate? This would then imply that everyone would receive a poorer quality of care. Do the expedited reviews and therapies increase the waiting time for patients injured outside of work for consultations or therapies, whether it be in an institution or in the physicians office? With respect to institutional costs covered by the WCB, there should be capacity to treat the WCB patients over and above the capacity provided by the Ministry of Health funding. However, it is probable that most institutions and many consulting providers do not manage the WCB funds in a way that creates extra capacity above the Ministry of Health funding and hence access of non-WCB patients may be decreased. These issues then become larger than the WCB alone and have significant ethical and political overtones. Unfortunately, data to argue for or against each of these questions is limited or non-existent.
Conclusion 20. Assess the Ethical Implications to the WCB Unique Fee System:

The WCB, with the support of the Ministry of Health and the Centre for Applied Ethics at UBC, should lead an ethical review of the payment systems with regard to the generation of a two-tiered system and appropriate access to ensure good quality of care.

One of the potential corollaries that is derived from the above argument is that the WCB may be processing injured workers faster and with better outcomes than for other British Columbians injured in other activities such as sports, vehicular accidents, at home, etc.. If that is the case, then the approach to injuries should be changed outside the WCB. Physicians and others must be educated, and the WCB staff would be the appropriate group to take the leadership role in this change of management for injuries. If they have data that is not generally available or utilized, they should be sharing it. If they do not, and there is a strong political movement to limit the expedited review, then people injured at work may no longer receive their expedited reviews and surgeries. WCB cannot be accountable for ensuring a change will occur, but they could be accountable for providing the education necessary for the relevant clinicians. This concept then is a derivative of the Provincial leadership role for the WCB, outside of workplace related injuries.

Conclusion 21: Educate Clinicians Regarding the Benefit of Early Intervention:

The WCB should take a leadership role in educating physicians and organizations as to the benefit of early intervention in various types of injuries, whether they be work related or not.

4.12.4 Distribution of WCB Physician Funds Amongst Physicians

The final component of the physician funding issues relates to the distribution of funds paid to the physicians of the Province. There are a small number of physicians who interact with the WCB to a large extent (in 1993, 149 general practitioners (out of a total of about 3,000) billed more than $24,000 each or alternatively 94 GP's accounted for 50% of the general practitioner billing to the WCB; the specialists were similar with 89 out of approximately 3000 billing $24,000 or more, and 147 billing more than 50% of the total specialists' billing). Conversely, there are a large number of physicians who have limited contact with the WCB patients. Both of these groups of physicians will require some leadership from the WCB to ensure good clinical outcomes and 'value for money'. The group of significant users will need to be educated and updated as much as possible on the most effective and efficient forms of therapy for the problems they commonly see. They will also be much more independent in many respects, but more in need of education and feedback from the WCB on their own utilization patterns. The second group that utilizes WCB infrequently would need to have rapid and responsive information for almost every patient they see essentially as soon as they see them ('just in time' guidelines — see section 4.9). Therefore, the challenges of providing information and support are quite different for these two major groups of outside physicians.

The WCB is considering an information system which will provide additional comparisons between and amongst physicians that treat WCB patients. This concept, to identify outliers and those who have excellent outcomes, has considerable potential power but also considerable potential negative impact, especially in the realm of 'medical politics'. This should be approached from the perspective of good principles of utilization management and the provision of effective clinical services. To address this issue with regard to finances and resource consumption alone is extremely risky and may lead to conclusions which improve the cost of rehabilitation on a short term but significantly decrease the quality of care and clinical outcome in the longer run. Financially driven systems are typically not as effective. It is critical to reinforce the clinical outcome component of this endeavour.
Conclusion 22. Develop an Outcome Oriented Assessment of Clinical Variability: The WCB should embark on assessments of variability in clinical outcome and resource utilization using well accepted, supported and beneficial principles of a good utilization management program. Care must be taken to ensure good communication of the program, the expectations of the individuals involved and the beneficial outcomes, clinical and resource consumption, that can and are being achieved. The utilization management program must be accountable for improving the effectiveness, efficiency and appropriateness of the quality of care provided.

4.13 Utilization Management, Risk Management and Quality Improvement

In interviewing people and reviewing documents, it is apparent that there is relatively little activity with respect to Utilization Management and Risk Management. The concept of Continuous Quality Improvement is supported although it was difficult to determine how much it was being utilized. Each of these activities can provide needed functions to the WCB.

4.13.1 Utilization Management

Utilization management, the study of how to efficiently, effectively and appropriately apply the resources of the institution to achieve optimum outcomes, is a rather complex field in health care. It does require a clear delineation of goals, an understanding of the processes utilized, and a mechanism to assess the outcomes. It is often project based, i.e., applied to specific problems or clinical situations, using techniques of continuous quality improvement as the tools for analysis. For the WCB, there is a degree of complexity that is not faced by other institutions. That is, so much of the WCB activities occur in other facilities with other staff, that the WCB control is somewhat limited. Nevertheless, the WCB component of Utilization Management could be by leadership, describing where some techniques are being done well, and providing guidelines to those who do services for the WCB. In fact, the future of Utilization Management in WCB purchased services might be based upon providers proving their efficiencies before an agreement for the services will be signed.

4.13.2 Risk Management

Risk management is another poorly functioning area in the WCB. There are risks to the patients under the direct care of the clinicians but the WCB physicians will be more at risk as it begins to give out guidelines to providers for specific clinical care cases. This is particularly true for Case Management. In fact, the WCB will need to ensure that the attending physician recognizes the important role played in ensuring the patient is receiving appropriate care. The WCB and the physicians should use guidelines but question it for those individual patients who do not follow the typical pathway.

Conclusion 23. Implement Programs in Utilization and Risk Management: The WCB should design and implement programs in Utilization Management and Risk Management. The programs should be held accountable for achieving their goals.

4.13.3 Physicians Legal Liability

Recently, a review by the BC Court of Appeals sought to resolve whether a non-WCB physician who managed a WCB case could be sued for negligence. In the existing Workers Compensation legis-
lation, it states that workers or employers cannot be held at fault for a work related injury. This is an underlying principle of the fault free system. The functional interpretation of the existing legislation in a situation of mishap by a physician on an injured worker, has been that the worker was receiving medical therapy as a result of an earlier injury, the therapy was being provided by the physician in the context of his/her work and therefore the worker was still in a work related environment and no fault could be assigned. The physician is also covered with respect to the WCB legislation as an employer or an employee. Although the outcome of the Appeals Court ruling is somewhat confusing, it appears as though negative consequences resulting from the therapeutic intervention by the physician are not considered part of the initial work related injury. Therefore, the WCB would not be required to compensate for the consequences of the therapy, i.e., the WCB is not financially accountable for the negative consequences which occur. Furthermore, it appears that the physician involved can be sued by the worker, but not by the WCB, for possible negligence of the intervention.

This complex example could be considered in the context of the therapeutic model being proposed in this paper, to see if it is useful to rationalize this issue. A few other principles need to be established in order to proceed. First, the WCB is accountable for the professional performance of its 'employees'. Second, it enters into contracts with other health care providers which require adequate performance, or, presumably, the contract will not be renewed. Therefore, if the mandate of the WCB is to provide the optimum clinical recovery of the injured worker, then they need to be aware of the performance of the health care providers with whom they contract, directly or indirectly, explicitly or implicitly. There would be a need to provide guidance in the form of education and guidelines, monitoring of the clinical progress of the worker, and feedback to the provider as to whether he/she/it is performing up to the average (or better yet, to educate as to the best (benchmark) methods) for the treatment of the condition involved. If the provider is not up to the standard, then most providers would want to know this and to improve their methods.

The WCB should expect the service is to be provided by its contractors with due diligence and appropriate standard of care, based in a contract, written or implied. If a provider, physician or institution, has an untoward outcome for a particular patient, then one could consider this in the context of the contractual relationship between WCB and providers, not as worker, employer and/or employee. But in some medical therapies, there are untoward affects that are rare but not unexpected that do not imply negligence or 'active incompetence'. In many assessments of negligence, there is an active component that must be demonstrated to determine negligence, not just a passive unfortunate complication. The WCB has a responsibility to know the quality of care that is being provided to 'their' injured workers, to educate providers and improve the care, and not to use providers who have poorer quality outcomes. The WCB should however not be the ones who decide as to whether an external physician is incompetent or negligent. That should be handled by the present methods of hospital or College review processes. The WCB should be accountable for understanding the quality of their 'contractors', but not trying to define and prove negligence. If the WCB is aware of a provider who is providing a significantly poorer quality of care, then the WCB should be accountable for that knowledge and work to resolve the problem via education, but potentially cancelling or suspending the physicians right to treat WCB patients, and informing the necessary bodies regarding the information. Present legislation permits the WCB to cancel or suspend a physician's right to be selected by a worker for medical care for not submitting prompt, adequate and accurate reports\(^\text{19}\). There is no statement that the physician can lose his/her right to be selected by an injured worker if the physician is not performing up to acceptable standards, although there is some implication that it could occur\(^\text{20}\). This is not adequately supportive of the mandate of the WCB to provide, directly or indirectly, adequate quality of clinical care and may require revision.

With respect to the compensation to the injured worker, the therapeutic model would suggest that the injury could not be fixed by the WCB and its contractors, hence compensation for the initial injury

\(^{19}\) Workers Compensation Act, Duty of Physician or Practitioner, Chapter 437, 56(5).

\(^{20}\) Workers Compensation Act, Medical Aid, Chapter 437, 21(6) and (7).
would still be the responsibility of the WCB. It was not responsible for any negligence of physician con-
tractor however.

In summary, the following points derive from the above discussion:

1. the WCB should be aware of the quality of care that is being provided within their health
care delivery system, including practitioners in explicit or implied contracts,

2. the WCB should not be accountable for ‘judging’ competence, but when their data suggests
that a provider is not achieving a given standard, education should be given, and if neces-
sary, the information turned over the the appropriate hospital or College,

3. the judgement of incompetence or negligence should be assessed by the appropriate hospi-
tal or the College, and

4. the health care provider must be accountable for the quality of health care they provide
within the WCB system as they are in the non-WCB system, and could therefore, be sued
as a last resort,

Although the WCB physicians appear to be 'protected' from suit under legislation, they are not
above the quality and behavioral expectations of the College of Physicisn and Surgeons of B.C.. Com-
plaints received by the College regarding the quality of care or behaviour of these physicians will be for-
warded to the WCB for complete investigation, as is done with other health institutions, and a full report
expected. Subsequent investigation by the College directly is still feasible. Furthermore, like the basic
finding of the investigation into the Canadian blood supply, the role of medical, and non-medical admin-
istrators in the WCB is to ensure that the best form of clinical care is provided without decision making
being inappropriately affected by the secondary (but important) issues of finances or compensation.

Conclusion 24. Resolve Legal and Financial Accountabilities for Medical Mis-
haps: WCB must be accountable for knowing the quality of care being given
in its health care treatment system. The legislation may need to be changed to
ensure that the WCB gathers the relevant data and has the accountability and
authority to act upon it, but the WCB should not be charged with adjudicat-
ing professional competence. Physicians need to be accountable for their
standards, as they are at present within the non-WCB health care system.

4.14 Administrative Structures in Medicine at the WCB

Some years ago, there was a change at the Senior Executive Committee such that a senior physician
was no longer included. The perception of many of the physicians at the WCB was that that action was
"anti-doctor". Given the major thrust of the clinical care component of the mandate, the Senior Execu-
tive Committee should be restructured to include a clinical leader. Furthermore, this individual must
play a role outside the WCB by linking with relevant Ministry of Health officials, provider partners,
community clinicians and their Colleges, provincial health related committees such as the Advisory
Committee on Clinical Resource Management, and Provincial and National educational/research insti-
tutions.

Clearly not all of the clinical care is dependent on physicians. There is a strong support given to the
interdisciplinary care within the Continuum of Care model and the Case Management model. Many
institutions such as the BC Cancer Agency have benefited from a multidisciplinary Professional Advis-
ory Committee (PAC), to advise their senior executives on the clinical challenges facing the organization. The terms of reference could deal with quality of care issues within and between the professions, with implementing new programs, with interdisciplinary management issues, etc.. The mandate should be advisory only. This would certainly help the problem perceived by many physicians who felt the
senior executive did not understand the clinical issues very well. The chair person of the PAC could also be a member of the Senior Executive Committee.

**Conclusion 25. Establish a Professional Advisory Committee and Include a Clinician on the Senior Executive:** The WCB should create a multidisciplinary Professional Advisory Committee (PAC) to advise on clinically relevant matters. The senior executive committee should be expanded to include the senior physician within the institution, and perhaps the chair of the PAC.
5.0 THE FUTURE MODELS AND PHYSICIAN ROLE

5.1 Case Management Model

The proposed model of case management offers opportunity for improvement in the way that the clinical care and claims process are managed. There are two major concepts underlying the case management model: that early intervention increases the possibility of a durable return to work; and, that having one contact person for a case will increase the coordination and resource support for those who are involved in the management of the case, and for the worker as well. There is literature to support both of these underlying concepts. High risk cases will be identified according to predetermined criteria:

- a clinically complex injury such as a head injury,
- a prolonged recovery period of greater than 4 weeks,
- a complex previous history of claims, or
- difficult underlying psychosocial issues including job availability.

The role of the case manager is to oversee service delivery and guide progress to achieving safe and durable RTW. If the case presents unusual characteristics, the case manager "may obtain input advice from the WCB expert team before proceeding further." The team will include a medical advisor, vocational rehabilitation consultant, psychologists and disability awards specialist; an occupational health nurse may be involved. The case manager may contact the attending physician or refer the case to the medical advisor or other clinicians for consultation.

In the approach, the case manager will have a critically important role to play in acting as a contact with the worker, internal staff and external therapists. Using appropriate general guidelines, case specific plans (guidelines in a generic use of the word -see section 4.9) will be developed with care provision outlined, and anticipated milestones, outcomes and time lines so that it will be known when the progress is not as expected. The case manager will interact with the medical adviser and the nursing advisor internal to the WCB to ensure that there is adequate clinical input for the clinical issues relevant to the case. Further description of the model will not be given here as there are many written materials.

5.1.1 Issues of Concern and Items of Caution for Case Management

It must be stated that these authors are highly supportive of the case management model. There are some issues that we wish to raise, not to imply any lack of support for the model but rather to provide some areas that are not obviously covered that could be improved in the implementation and operation of the model.

With respect to the medical advisors, the contact planned with the community physicians is appropriate and advisable. This will have two major consequences, namely improve the credibility amongst the community physicians of the WCB medical staff, and allow the WCB physicians to play a role that is proactive and supportive of clinical improvement for the worker.

However, in the revised model, the medical advisor may be less involved with the patient directly, even less than in the past. Although providing considerable contact with the attending physician, there is a probability that the WCB physician will see fewer patients and become mainly an educationally oriented resource person. The risk of this is two-fold. If the case is clinically complex as in some soft tissue or head injuries, the expertise of the WCB physician is critical to the actual 'hands on' management of the case. The WCB physician should see the clinically complex cases. Secondly, with less contact with patients, the clinical acumen of the WCB physicians may decrease. They will lose their clinical expertise over time and new recruits to the WCB will not have the opportunity to develop their own expertise. It is critical to ensure that the physicians have enough clinical exposure to warrant and maintain the sta-

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21 Case Management Conceptual Model
tus as clinical experts in the area of clinical management of the injured worker. The physician must be 'up front and centre' for the complex, challenging cases, the resource expert for the attending general physician. See also conclusion 8.

The concept of multidisciplinary care inherent in the case management model implies that there is a tremendous dependency on teamwork and on individual members of the team. Given the probability of only one medical advisor and one nurse advisor, and the critical role that they play in the team, there must be an organizational readiness to monitor and respond to those teams that may be having internal difficulties. That is not to say it should be expected but with considerable pressure on such small teams, individual members of the team are critical as are group dynamics. It will also require careful attention to provide appropriate relief coverage and succession planning.

Another concern is that there is absolutely no mention in the document of assuring successful clinical outcomes as a desired goal. The Quality Assurance framework examines the process itself, but not the outcomes of care (save if they returned to work in a timely fashion) nor does it appear to address such things as assessing inappropriate therapies (both under and over utilization as well as incorrect procedure choices). Perhaps the case described in Section 1.4 above could be considered again, the injured labourer with a complex shoulder injury who is however part way through a training program in computer programming. Is the return to work the only outcome measure of interest, or the only information to be gathered? These comparative outcomes need to be assessed in the intermediate and long term so that there is evidence available to assess whether the correct decisions were made. It must be acknowledged that our knowledge of prevention stems from our understanding of the process of care, care requirements and medical outcomes.

It should be noted that this model has a great potential for improving the function of the WCB in many ways, and consequently deserves regular evaluation and improvement.

**Conclusion 26. Expand Case Management to All Centre/Regions: The WCB should continue to develop and disseminate the case management model. Particular attention should be paid to the potential areas of risk described above. The WCB should be accountable to do a clinically relevant (and other variables) evaluation on an ongoing regular basis. It must be assessed to detect strengths and weaknesses and improved continuously.**

**5.2 The Role of Physicians within the WCB**

A major previous report seriously considered separating or deleting the medical component of the WCB, to make an independent entity or to disband it altogether and use community physicians as necessary for the clinical care\(^22\). This review does not recommend either of those options, but rather recommends that the WCB physician role be expanded within the WCB, largely as outlined above. The mandate of the WCB, as perceived by these authors, and the implied disagreement with the Fulton/Atkinson report by not acting on the recommendation, lead us to recommend that the role of the medical staff within the WCB should be enhanced, clarified, supported and evaluated.

The mandate of the WCB should appropriately contain reference to the clinical care of the injured worker and prevention of injuries and occupational diseases. It would be difficult to acknowledge any other organization that could take the leadership role in this area, and given the number, and the social and fiscal importance of work related health problems, it is critical that some organization accept that Provincial leadership mandate. It is recommended that the WCB accept that responsibility (conclusion 11).

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\(^{22}\) Medical and Rehabilitation Programs in Workers' Compensation: An Administrative Inventory in BC. J Fulton and J Atkinson, 1993.
Given a commitment to the clinical mandate, the medical staff of the WCB will play an integral role as leading members in the interdisciplinary teams. This is not to imply that the physicians are to necessarily be the leaders of the team, but they must, because of their knowledge base being significantly different from the majority of other team members, be expected to be and accountable as providers of leadership with respect to clinical care initiatives.

One of the outcomes of the above discussion and the conclusion that follows relates back to conclusions 4 - 8, the role of physicians and other team members. It is probable that the real outcome of many of these changes will be to acknowledge the ongoing need to provide medical advice to the compensation process, but also to ensure that the role of physicians in research, education, and provincial leadership is enhanced and that rehabilitation and prevention is maintained and improved. Furthermore, rehabilitation, prevention and research must interact well in support of the other activity. In doing this, physicians have the opportunity to break down some of the 'silos and stovepipes' characteristic of the WCB that many interviewees described. Finally, the physicians focused predominantly on compensation must maintain (adequate) clinical skills in rehabilitation medicine as their credibility will be dependent in the case management model to work as effective and knowledgeable advisors.

Conclusion 27. Expand the Role of Physicians within the WCB: The WCB should maintain physicians as part of the organization. The physicians' role in the WCB should be expanded, the WCB should support them in this role and hold them accountable it. The physicians should:

- be and be perceived to be clinical experts in the diagnosis, treatment and outcomes of clinically complex cases of work related injury or disease;
- act as a credible resource to clinicians, medical and nonmedical, across the Province;
- play an integral role in the development, dissemination, monitoring and improving of guidelines and other standardized objective tools;
- play a leading role in the continuous improvement of clinical care and utilization of resources with respect to work related injury or disease;
- take part in, or actively support research oriented activities directed at better understanding work related injuries and disease, and improving the safety of the workplace; and, 
- provide knowledgeable, unbiased information to claims adjudicators or case managers for the adjudication of claims.

The order, and hence priority, of these roles as listed is intentional. The above tasks suggest that who does what within the WCB medical staff will likely change, will require new or augmented skill sets and may require new recruits. Some degree of separation between functional responsibilities is required but with significant interactions and mutual support.
6.0 CONCLUSIONS

A list of the conclusions is provided. The shortened version appears first in the table.

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SUMMARY OF CONCLUSIONS

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FULL CONCLUSIONS

1. **Clarify Strategic Vision:** The WCB should clarify its major mandate and the roles of each of the major groups and divisions within the organization. The importance of clinical care as embodied in the therapeutic model should be reinforced.

2. **Utilize an Accountability Framework:** The WCB Senior Executive Committee should adopt an accountability framework such as the CCAF guidelines as the management tool for monitoring accountability of the leadership group. The framework should be adapted to all other segments of the organization.

3. **Create a Learning Environment:** Medical administration should promote a learning environment and learning expectation for WCB physicians. Physicians should be accountable for their continuing medical education, for sharing knowledge with other clinicians inside the WCB, and conversely, learning from other clinicians.
4. **Develop A Comprehensive Medical Human Resource Plan:** The WCB should develop a comprehensive medical human resource plan. This should include:

- a more detailed assessment of the number and type of physicians required in the future as influenced by retirement and changing programs;
- a firm policy that the retirement age is 65 years unless there is a specific need of the WCB;
- a clear enunciation of the skill sets required by the WCB physicians especially given the probability of role change;
- a specific plan for the recruitment, retention and training of physicians in the WCB; and
- the description of a training program which would provide individuals with the knowledge and skills required (this could be in conjunction with other Workers’ Compensation organizations across Canada).

5. **Develop Medical Responsibilities, Accountabilities and Regular Evaluation Mechanisms:** That the WCB develop clear responsibilities and accountabilities for the various medical positions (job descriptions and performance evaluations). The major functions of the positions must be consistent with the mandate of the organization. The performance evaluation mechanism should include measures of "customer input", measurable outcomes and clear evidence of ongoing commitment to a learning environment.

6. **Clarify and Publicize Role of WCB and Attending Physicians:** The WCB should clarify the role of the WCB physician and the attending physician to include the points outlined in tables 2 and 3, and ensure they are appropriately and regularly communicated. Enhanced contact between the WCB and attending physicians will be the basis for improved credibility and secure collegial relationships. Significant effort must be made by the WCB physicians to make this contact in a manner outlined.

7. **Clarify and Publicize the Role of Treatment Team Members:** The WCB should clarify the role of the members of the treatment team, including the patient, in case management. This information should be provided to every patient entering the case management care model.

8. **Encourage Contact Between WCB Physicians and Patients:** The WCB physicians should be active participants in direct contact with patients/workers especially in claims likely to be, or which are, in fact, rejected. This direct contact should be either in an office setting or via telephone. It should however not be outside the defined role of the WCB physicians.

9. **Analyze Appeals Outcomes:** Analyze the outcomes of the Medical Review Panel, and possibly other appeal decisions, to determine the reasons for overturning the decision, to assess what could have been done differently in the early adjudication phase, to assess if adjudications are in any way biased, and improve on the processing of claims, at least in the context of the medical/clinical input

10. **Address Policy Development:** The WCB should review the medical policies in place to determine if they are consistent with current clinical knowledge, and consistent with one another. A mechanism for bringing forward inconsistent policies must be established.

11. **Enhance the Provincial Leadership Role:** The WCB should actively pursue the leadership role inherent in a mandate that includes Provincial leadership in care of the worker with injury or disease.

12. **Establish/Enhance a Clinical Research Mandate:** The WCB should make a commitment to research for the acquisition of new knowledge into the causes, treatment and prevention of work related injuries and occupational diseases in British Columbia.
13. **Utilize Clinical Guidelines**: The WCB should enhance their commitment to the use of objective standards of care or guidelines\(^{23}\) in managing the injured worker. Efforts will be required to ensure that the guidelines are appropriately followed by the attending physician, and that they continually be improved, based upon clinically relevant evidence which is appropriately provided to the clinicians involved.

14. **Utilize Clinically Relevant Performance Indicators**: Clinically relevant performance indicators, not just indirectly related financial or utilization indicators, should be developed. An excellent (but not exclusive) source of good clinical performance indicators are the key measures from the guidelines used to monitor the clinical progress of the injured workers.

15. **Complete the Design of a Clinical Information System**: The design of an information system relevant to the clinical needs of the WCB should be completed using a clear "systems thinking" approach to the clinical mandate\(^{24}\).

16. **Continue with the Integrated Database Project**: The WCB should continue to submit data to the large UBC-based data integration project, and become active users of the information for their own questions.

17. **Review WCB Physicians Salaries**: The Human Resources Department at WCB should review the physicians' remuneration packages provided by workers' compensation boards across Canada and incomes of similarly qualified B. C. physicians to ensure equity. A reward system for salary should be developed which is aligned to the mandate and expectations of the WCB. The salary levels from other sources in the Province and across Canada should be communicated to the Medical Staff.

18. **Reallocate the Additional MSP-based Increment to the Benefits Pool within the MSP**: The Ministry of Health, BCMA and WCB should meet to discuss the transference of the 4% increment into the benefits component supplied within MSP and to allow the WCB fee for service component to qualify for benefits in the existing MSP agreement. The additional 2% should be reassessed annually based upon whether the electronic billing and reports are being utilized, and should ultimately be withdrawn.

19. **Negotiate Future Contracts with the Ministry of Health and the BCMA**: Serious consideration should be given to have all future negotiations pertaining to this contract handled in a tripartite manner to ensure consistency and equatability across the multiple physician related contracts in the Province.

20. **Assess the Ethical Implications to the WCB Unique Fee System**: The WCB, with the support of the Ministry of Health and the Centre for Applied Ethics at UBC, should lead an ethical review of the payment systems with regard to the generation of a two-tiered system and appropriate access to ensure good quality of care.

21. **Educate Clinicians Regarding the Benefit of Early Intervention**: The WCB should take a leadership role in educating physicians and organizations as to the benefit of early intervention in various types of injuries, whether they be work related or not.

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\(^{23}\) In this discussion, the term guideline is used generically to refer to clinical practise guidelines, clinical practise plans, protocols, pathways or algorithms, all of which in some way follow the flow of patient information, clinical care activities and anticipated or unexpected outcomes as part of the guidance for the clinicians involved in the patient care. The other terms listed above refer to slightly techniques and tools that are often utilized in specific situations. The use of the word 'guideline' here is not meant to pre-empt the use of any of these tools in the appropriate time or place.

22. **Develop an Outcome Oriented Assessment of Clinical Variability**: The WCB should embark on assessments of variability in clinical outcome and resource utilization using well accepted, supported and beneficial principles of a good utilization management program. Care must be taken to ensure good communication of the program, the expectations of the individuals involved and the beneficial outcomes, clinical and resource consumption, that can and are being achieved. The utilization management program must be accountable for improving the effectiveness, efficiency and appropriateness of the quality of care provided.

23. **Implement Programs in Utilization and Risk Management**: The WCB should design and implement programs in Utilization Management and Risk Management. The programs should be held accountable for achieving their goals.

24. **Resolve Legal and Financial Accountabilities for Medical Mishaps**: WCB must be accountable for knowing the quality of care being given in its health care treatment system. The legislation may need to be changed to ensure that the WCB gathers the relevant data and has the accountability and authority to act upon it, but the WCB should not be charged with adjudicating professional competence. Physicians need to be accountable for their standards, as they are at present within the non-WCB health care system.

25. **Establish a Professional Advisory Committee and Include a Clinician on the Senior Executive**: The WCB should create a multidisciplinary Professional Advisory Committee (PAC) to advise on clinically relevant matters. The senior executive committee should be expanded to include the senior physician within the institution, and perhaps the chair of the PAC.

26. **Expand Case Management to All Centre/Regions**: The WCB should continue to develop and disseminate the case management model. Particular attention should be paid to the potential areas of risk described above. The WCB should be accountable to do a clinically relevant (and other variables) evaluation on an ongoing regular basis. It must be assessed to detect strengths and weaknesses and improved continuously.

27. **Expand the Role of Physicians within the WCB**: The WCB should maintain physicians as part of the organization. The physicians' role in the WCB should be expanded, the WCB should support them in this role and hold them accountable it. The physicians should:

- be and be perceived to be clinical experts in the diagnosis, treatment and outcomes of clinically complex cases of work related injury or disease;
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- play an integral role in the development, dissemination, monitoring and improving of guidelines and other standardized objective tools;
- play a leading role in the continuous improvement of clinical care and utilization of resources with respect to work related injury or disease;
- they should take part in, or actively support research oriented activities directed at better understanding work related injuries and disease, and improving the safety of the workplace; and,
- they should provide knowledgeable, unbiased information to claims adjudicators or case managers for the adjudication of claims.
APPENDIX A

TERMS OF REFERENCE OF REVIEW

The following objectives will be considered utilizing data, documents and personal interviews.

Objective 1. What are the past, current and future plans for clinical organization and services?

This will be accomplished by reviewing the organizational structure, the past and future plans for the medical services, meeting with several physicians inside and outside the WCB, and reviewing minutes of appropriate committees. Results of this review will be interpreted with respect to the effectiveness of the service delivery model, the clarity of the goals and objectives plus the consistency of the incentive with respect to the medical activities in the WCB. Particular attention should be paid to the goals and objectives of the medical services component, and to the relationship that the WCB physicians have with their colleagues in the community.

Objective 2. What are the incentives and patterns of practice within the medical staff?

This must be addressed at a level that is outside the WCB. It requires assessment of the past and current agreement between the BCMA and MSP, plus the understanding of differences in fee for service and capitation/clawback regulations. This will be completed by appropriate interviews with knowledgeable individuals from BCMA and the Ministry of Health plus the review of appropriate agreements. Assessment will be made of the process followed for determination of a claim, and what information is provided to the referring MD if the WCB turns down the claim. A description of the risk management issues for the WCB and the medical staff will be discussed.

Objective 3. How are quality of care, clinical competency and risk management managed?

Specific pieces of information relevant to this objective include accreditation reviews recently completed, results of the program evaluation review unit, existing mechanisms for Quality Review and feedback within the WCB, and adequacy of the support provided to physicians practicing outside of the WCB but related to prevention or treatment of injuries. This section will need to focus on measurement of outcomes and the clinical effectiveness required to achieve good outcomes. This latter aspect will be closely aligned to the question of what the mandate of the WCB is. It may be that the clinical function provided is not clearly aligned with the overall mandate of the WCB. A better understanding of the information system in existence plus the design of the future system will be required in order to determine the ability of the information system to support the clinical requirements, particularly as related to the quality of care and assessment of outcomes.

Objective 4. What is the utilization and usefulness of documented standards of care in rehabilitation medicine?

The use of guidelines is rapidly expanding in many areas of clinical medicine. The relevance of guidelines to rehabilitation medicine will be assessed and the use of these guidelines in other constituencies will be determined. Although guidelines can provide a standard approach to a problem, their use must be understood on a continuing basis and hence will have impact on the information system currently being designed.

The final report will include an interpretation of the information plus recommendations that may be relevant in each section. Many of these objectives can, and will, be considered in the context of the CCAF guidelines on effectiveness, to be consistent with the approach being recommended in other areas and reports to the Commission.
APPENDIX B

INTERVIEWS HELD

WCB Staff and Affiliated People

Dr. David Blair
Mr. Ron Buckhorn
Dr. Ian Connell
Dr. Ralph Didcott
Dr. Greg Feehan
Dr. Don Graham, Prince George
Dr. David Hunt
Mr. Richard Hurst
Dr. Jamie Naismith, Victoria
Dr. David Newman
Dr. Klaas Postma
Mr. Mark Powers
Dr. William Whitehead

Individuals Outside WCB

Dr. Hugh Anton, Head, Division of Rehabilitation Medicine, UBC
Dr. Claire Bombardier, Senior Scientist, Institute for Work and Health, U of T
Dr. Clyde Hertzman, Occupational Health Physician, UBC
Dr. Neva Hilliard, Occupational Health Physician, BC
Ms. Judith Lee, Lawyer with special interest in issues of the Injured Worker
Mr. Murray Lott, Lawyer with special interest in issues of the Injured Worker
Dr. Stanley Lubin, Family Physician and (previous) Head of UBC Family Practise Postgraduate Education
Dr. Howard Platt, Ministry of Health
Dr. John Sehmer, Family Physician, with interest in Occupational Medicine and former chair of the BCMA Section of Occupational Medicine
Dr. Brian Taylor, Assistant Deputy Registrar, College of Physicians and Surgeons of BC
Dr. Tom Ward, Senior Consultant, St. Paul's Hospital
APPENDIX C

The Following Documents Were Reviewed in Assessment of the Medical Issues Project:

A Review of WCB Cases Treated in St. Paul's Chronic Pain Program
Accountability Reporting Review by Auditor General of BC
Administrative Inventories: is the Methodology Sound? June 1997
Alberta WCB Medical Advisory Guidelines (S. McKay)
An Overview of the Historical Development and Current Structure of the WCB of BC, Nov 1996
Attending Physicians Handbook, April 1997
Auditor General's Accountability Recommendations — WCB Response to:
BC Healthcare Risk Management Society, Definition of Terms (risk management, quality assurance, total quality improvement)
BC Medical Association (BCMA) Submission to the Royal Commission on Workers' Compensation, November 1997.
Case Management Conceptual Model, January 1997
Chapter 3: Compensation for Personal Injury.
Chapter 10: Medical Assistance
Clinical Practice Guidelines for the Diagnosis and Treatment of Low Back Pain
Collaboration WCB (D. Blair, BCMJ 40:151, 1998)
Cost Analysis: Health Care Benefits
Doctors, Diagnosis and Disability: A Disastrous Diversion (JD Loeser, and M Sullivan, Clin Orthopaedics and Rel Res, 336, 61, 1997)
Dr. Blair's Slides for Presentation, February, 1998
Fee for Service Agreement Between the WCB and the BCMA (January, 1998).
Forms 8 and 11.
Hansard Vol. 4, No. 20, pg 51-53.
Health Care Services Program 2000: Phase I: Business Solution Development
Job Descriptions: Team Assistants, Case Manager (and Case Manager Prototype from Performance Solutions International), Entitlement Officer, Nurse Advisor, Claims Officer I and II, Case Assistant, Vocational Coordinator, Vocational Rehabilitation Consultant, Medical Appeals Officer, Occupational Safety and Hygiene Officers from Prevention, Program Manager from Prevention Services, and those from the Psychology Department.
Medical Advisory Committee, Terms of Reference, 1997.
Medical and Rehabilitation Programs in Workers' Compensation: An Administrative Inventory in BC. J Fulton and J Atkinson, 1993.
Medical Treatment Guidelines in Washington Workers' Compensation (G Franklin, R Plaeger-Brockway), Available on the Internet from Washington State Department of Labor and Industries.
Memorandums of Agreement and Fee Schedules
Ministry of Health and Ministry Responsible for Seniors Submission to the Royal Commission on Workers' Compensation, January 1998.
MRI of the Spine in A Compensation Setting
Overview of Customer Satisfaction Survey Project, and associated WCB Claimant Satisfaction Reports.
Performance Measures: Definitions: March 1997
Procedure Manual for Physicians
Rehabilitation and Compensation Services Division: 1998 Business Plan
Report on Sections 2 and 3a of the Commission's Terms of Reference: October 1997
Salaried Physicians Agreement
Presentation transcripts to Royal Commission Hearings, key words sought in a generic search format included:
  adjudicator and accountability
  credentials and qualifications
  adjudicator and decisions
  adjudicator and rejections
  role or function or criteria and adjudicator
  delay and decision
  specialist or doctor or physician and accountability
specialist or doctor or physician and decision
specialist or doctor or physician and education
specialist or doctor or physician and opinion
specialist or doctor or physician and overrule
specialist or doctor or physician and recommendation
specialist or doctor or physician and role
medical and advisors
credentials or qualifications
rejection
practise guidelines

Somatization and Chronic Pain in Historic Perspective (E Shorter, Clin Orthopaedics and Rel Res, 336:52, 1997)


Technology Assessment Committee: Terms of Reference

The Clinical Practise Parameters Movement: the Risk Manager's Role

The Excess Costs of Health Care for Work-Related Injuries. The Zenith Report Number 1, WG Johnson, ML Baldwin, SC Marcus, JF Burton.

The Need for an Evidence-based Approach to Medical Services (B. Lauber, Alberta)


The WCB and the University: An Alberta Partnership (TL Guidotti)

Toward Total Care Management: The Integration of demand, disease and case management programs can help MCOs provide employers with nearly total management of employee health care. KL Birch, www.towers.com

Transforming the Workers' Compensation Board of British Columbia: A Strategic Plan. April, 1996


Victoria Menisectomy Review

WCB/BCMA Agreement Information Update (from BCMA)

WCB Billing Guide: How to bill the WCB with MSP Teleplan (from BCMA)


WCB Salaried Physicians, list of credentials, 1998.


Workers’ Compensation Act, Chapter 437, part 1, divisions 1 and 2 (including Schedule B), and sections 21, 56, and 57.
APPENDIX D

The reviewers would like to thank the many people who shared their knowledge, impressions, concerns and ideas during the reviews period. We appreciated your commitment to improving this important service for the workers.

Specific individuals were very helpful in trying to track down people, documents, information and computer or library searches. In particular, we would like to thank Angie Weltz, researcher at the Royal Commission, for her ideas and relevant documents; Gerry Schive, computer wizard at the Royal Commission for his advice and assistance at retrieving vital information; Dr. Dewey Evans, Director of Utilization in the Calgary Regional Health Authority, for his feedback, advice and challenging ideas; Dr. John Sehmer, for his constructive advice and insights; Dr. David Blair, Medical Director at the WCB for his time, patience, information and candid comments about a system to which he is committed; and Ms. Sheila Wong, secretary to Dr. Blair for her pleasant, helpful assistance at finding information and people all at the last minute.

Thank you to you all.
APPENDIX E

EIGHT IMPORTANT STEPS IN MANAGING CHANGE IN AN ORGANIZATION

1. establish a sense of urgency
2. form a powerful guiding coalition
3. create a vision
4. communicate the vision
5. empower others to act on the vision
6. plan for and create short-term wins
7. consolidate improvements and produce still more change
8. institutionalize new approaches

from Leading Change: Why Transformation Efforts Fail", Kotter, JP,
APPENDIX F

ROLE OF LEADERS IN MAJOR ORGANIZATIONAL CHANGE
PRINCIPLES OF ORGANIZATIONAL JUSTICE

(notes from a lecture by Dr. G. Latham, Professor, Faculty of Business, University of Toronto)

In any major change process, there are several characteristic responses that occur. Hence some general roles and attitudes should be planned by the leadership. The attitudes should be typical of good leadership in more stable times as well. The information provided below is a list of suggested behaviours for the leaders to consider and follow.

The following discussions relate to the leadership characteristics of Organizational Justice. Organizational justice is composed of four major components and several corresponding steps and values.

COMPONENTS OF ORGANIZATIONAL JUSTICE

Distributive Justice

This concept relates to how resources are distributed during any change. This, perhaps surprisingly, is the least important of the four components in the long run.

Procedural Justice

This is the most important component. Procedural Justice requires that a process must be in place to manage the change, that there is acceptance that the process is followed, and that there is an appeal mechanism. Staff must feel they are being treated equally (fairness must be done as well as be perceived to be done). If the process is not procedurally fair, then those hurt by the change will likely not accept it. Those who are not hurt may still consider the process unfair, will ask "Will it be me next time - there are no apparent rules", and hence not be committed to the change. Those who are not hurt during the change may "suffer" from the "the survivor syndrome". In it, the survivor of change may feel guilty that (s)he survived while others didn't. If the process is unfair, it will cause loss of trust and poor subsequent commitment to the outcome.

Interactive Justice

Interactive Justice requires that the leadership must have a logical reason for doing what is to be done, and that the leaders must be sincere in their commitment to the change. If a logical explanation can be provided, staff will often take the stance "I may not agree with the outcome, but I understand the logic behind it". The logic, and therefore the proposed change, must be a benefit to the organization as a whole, and not just to one part of it. In this realm, leaders will have to be open to any questions, and often say "let me explain why".

Voice

Staff must feel that they can be and are being heard. They must feel they count. It need not mean that their preferences are implemented but they must know they were considered. In many aspects, there are often decisions made outside the control and authority of the staff or the organization itself. This decision to change is often top down in nature. However, implementation of change can and should be bottom up. In this way, voice in change is much greater. This does imply that during the implementation, some choices must be made which need to be delegated and the outcomes accepted by the leaders. This gives staff a voice in implementation although the decision for the change has already occurred.
PROCESS STEPS AND VALUES FOR IMPLEMENTATION

Vision

The vision of the organization should be inspirational, should give employees a cause to commit to, and be captured in one to three sentences. It should not be empty rhetoric, as employees may accept the vision but not be committed to it.

Goals

Goals provide for a transition from vision to action. They should provide a sense of challenge, and also give meaning to what could otherwise be considered meaningless labour. Goals should also be SMART, Specific, Measurable, Achievable, Relevant, and Time defined.

Vision will drive the behaviour, and goals will make it happen. In addressing this aspect, some questions that help develop these concepts are:

- why do we exist?
- who would miss us if we were gone?
- what is the primary source of discontent at present?

Integrity

During change, expected behaviour must be demonstrated by example. Unintended signals of discontent can be very revealing. Often the only way that a leader can determine if (s)he is showing these signs is to ask one's colleagues, preferably in an informal setting.

Accessibility

Leaders must show they are accessible, and that staff are appreciated. Typically this requires respect of the colleague, and attention to specific behaviours. By providing this attention, new and desirable behaviours can be rewarded.

Also, one must encourage discontent. This will detect misunderstandings, different meanings behind identical words, incorrect implementation choices and apathy. In fact, the ability to learn from discontent and/or failure is sometimes referred to as constructive discontent or celebrating failure. One must also be aware that being accessible can lead to exhaustion as good listeners are often sought out. Therefore, all must help. Accessibility provides the opportunity to facilitate learning and change behaviour. This is often done by asking questions to help the staff member solve the issues themselves. This is especially true in times of change.

CONCLUSIONS

These thoughts and behaviours are examples of what leaders must be prepared to do to facilitate a smooth transition to a new organization, to minimize negative impacts on those affected, and to provide the opportunity for creative, beneficial outcomes. The whole staff have an opportunity to set the tone for a smooth (or bumpy) transition, and for a creative (or not) new organization that can perhaps better contribute to the health and well being of the populations to be served.