ROYAL COMMISSION ON WORKERS’ COMPENSATION IN BRITISH COLUMBIA

TERMS OF REFERENCE ITEM 3(C) RELATING TO REHABILITATION AND RE-EMPLOYMENT MATTERS

FINAL REPORT

December 7, 1998

submitted by

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1. INTRODUCTION

1.1 Purpose of the Report

On December 1, 1997, the Royal Commission on Workers’ Compensation in British Columbia (the ‘Commission’) awarded research contract no. RCWC-019 to Rosemary Wallbank to conduct a review of the Workers’ Compensation Board of British Columbia’s (WCB) rehabilitation and re-employment activities. This report presents our findings and conclusions.

This research is concerned with item 3(c) of the Commission’s terms of reference, which grants authority:

To inquire into recurring and current issues pertaining to the operation and administration of the workers’ compensation system, and without limiting the number, nature and scope of these issues, to include

(c) rehabilitation and re-employment matters.
The scope of the rehabilitation component includes:

- Vocational Rehabilitation Services,
- Medical Services,
- Psychological Services, and
- the Leslie R. Peterson Rehabilitation Centre (the ‘Rehabilitation Centre’ or ‘Centre’).

It excludes Compensation Services, except where rehabilitation services and outcomes are directly or indirectly affected by Compensation Services Division activities, policies and functions.

The research approach was driven by the accountability framework as described by the Auditor General (see Appendix 1) and by the effectiveness attributes model as defined by the Canadian Comprehensive Audit Foundation (see Appendix 2). It comprises two parts: rehabilitation within the existing model, and options to the current model.

To address the WCB’s current delivery of rehabilitation (the existing model), eleven hypotheses were examined for each of the four programs listed above. These hypotheses are intended to assist the Commissioners to reach conclusions on such questions as:

- Are the right people receiving rehabilitation services?
- Are they receiving the right services?
- Are these services provided in an appropriate way?
- Are these services as useful as they could be?
- Are these services delivered in a cost-effective way?
- What improvements could be made or pursued, at what cost?

The second part of this report sets the WCB’s rehabilitation responsibilities in the larger picture (provincial, national and international) and looks at other ways in which these responsibilities could be fulfilled. The issues addressed through this research will assist the Commissioners to reach conclusions on such questions as:

- Are there more efficient and effective ways to fulfil the WCB’s rehabilitation responsibilities beyond the current model?
- Are there ways to fulfil these responsibilities that would be viewed as more equitable and fair by the stakeholders and the public in general?
- What would be the likely costs/savings and benefits/disadvantages related to these options?
- What steps would be required to implement these options?
1.2 The Research Team

A research team was assembled to conduct the work. Rosemary Wallbank served as team leader and was also responsible for vocational rehabilitation issues; Sylvia Robinson and Shannon Turner of The October Group took on responsibility for medical and psychological rehabilitation and the Leslie R. Peterson Rehabilitation Centre. Nancy Cameron provided research assistance to the research principals. Dr. John Sehmer provided expert medical advice.

1.3 Methodology

The evidence-based research and analysis combined comprehensive audit, program evaluation and performance measurement techniques, supplemented by a limited amount of peer review/expert opinion.

Data were collected from a wide variety of sources:

- **literature review**: related literature was identified through searches of the WCB’s library, the Internet and through personal knowledge. It includes literature related to rehabilitation in general, and to practices in selected jurisdictions as well as BC.

- **document review**: WCB documents were identified through library searches and through direct requests to WCB staff.

- **submissions to the Commission**: relevant submissions were identified by key word search. Submissions to be reviewed (from the hundreds identified) were initially selected by frequency of ‘hits’ i.e. those with the most frequent use of key words, and those in which several key words were identified. We subsequently conducted a second selection process to ensure coverage of as wide a range of presenters as possible.

- **questions directed to the WCB**: based on their initial research, the research team prepared a list of questions which were posed to the WCB in an attempt to elicit further information.

- **interviews**: individual interviews were conducted with 12 WCB representatives; a total of 36 staff participated in two group interviews with Psychology and Vocational Rehabilitation Services; 6 non-WCB persons were interviewed, 5 of them representatives from other organizations who provided information on how they provide rehabilitation services. (See appendix 3)

In addition, the team referred to work conducted by other researchers on behalf of the Commission.
Hundreds of working papers (see appendix 10), several CD’s, and approximately 140 submissions to the commission were reviewed. Even so, the research team was unable to answer certain questions fully and some of the evidence as reported in Appendices 4 to 7 is dated. The research was conducted over a fairly short time period which coincided with commission hearings at the Board, and with the physical move of at least one department. This impacted the Board’s ability to respond to the research team’s requests during the data collection time frame.

1.4 Report Presentation

Part 1 of this report deals with the existing WCB model in British Columbia. It provides a brief description of rehabilitation responsibilities and activities at the WCB, followed by overall findings relating to the existing model. Detailed findings and evidence by hypothesis for Vocational Rehabilitation, Medical Services, Psychology, and the Rehabilitation Centre are presented in Appendices 4 to 7 respectively.

Part 2 presents the research team’s findings on options.
PART 1

REHABILITATION AT THE
WORKERS’ COMPENSATION BOARD
OF BRITISH COLUMBIA

1. REHABILITATION RESPONSIBILITIES AND ACTIVITIES

The Board has established four program areas to meet its rehabilitation responsibilities. These are: Vocational Rehabilitation Services (VRS), Medical Services, Psychology, and the Leslie R. Peterson Rehabilitation Centre.

Vocational Rehabilitation Services is part of Compensation Services Division.

Until 1994, the Leslie R. Peterson Rehabilitation Centre, Medical Services and Psychology were part of Medical Services Division. In 1994, the Vice President, Medical Services left and the Medical Services Division was disbanded. Medical Services Department was placed within the Compensation Division while Psychology and the Rehabilitation Centre reported directly to the President/CEO.

In April 1996, Medical Services, Psychology and the Rehabilitation Centre were reconstituted as one Division — Rehabilitation Services — under the leadership of the same Vice President who is responsible for Compensation Services. His title is now Vice President, Rehabilitation and Compensation Services Divisions. As such, he is responsible for all rehabilitation including Vocational Rehabilitation Services.

The following four sections describe each of the four major program areas in terms of legislative mandate, major objectives and activities. This is followed by a review of resources allocated to rehabilitation activities.

1.1 Vocational Rehabilitation Services

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

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

2. Where compensation is payable under this Part as the result of the death of a worker, the board may make provisions and expenditures for the training or retraining of a surviving dependent spouse, regardless of the date of death.
The board may, where it considers it advisable, provide counselling and placement services to dependants.

It should be noted that the Royal Commission in its October 1997 report on sections 2 and 3(a) of the Commission’s terms of reference recommended that

- s.16(2) be amended to provide that, where such services have been requested and a need has been determined, ‘the board shall make provisions and expenditures for the training or retraining of a surviving dependent spouse, regardless of the date of death’; and
- s.16(3) be amended to provide that, where such services have been requested and a need has been determined, ‘the board shall provide counselling and placement services to dependants’.

Chapter 11 of the Rehabilitation Services and Claims Manual (the ‘Manual’) sets the policies governing the provision of vocational rehabilitation services.

Paragraph 85.20 defines **quality vocational rehabilitation**:

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

Vocational rehabilitation may also include **preventative rehabilitation**. The Vocational Rehabilitation Services Handbook RPH 060-006 July 1994 notes:

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

The manual presents seven principles to guide quality vocational rehabilitation:

1. Vocational rehabilitation should be initiated without delay and proceed in conjunction with medical treatment and physical rehabilitation to restore the worker’s capabilities as soon as possible.

2. Successful vocational rehabilitation requires that workers be motivated to take an active interest and initiative in their own rehabilitation. Vocational programs and services should, therefore, be offered and sustained in direct response to the commitment and determination of workers to re-establish themselves.
3. Maximum success in vocational rehabilitation requires that different approaches be used in response to the unique needs of each individual.

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

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

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

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

The objectives of Vocational Rehabilitation Services are:

1. To assist workers in their efforts to return to their pre-injury employment or to an occupational category comparable in terms of earning capacity to the pre-injury occupation.

2. To provide the assistance considered reasonably necessary to overcome the immediate and long-term vocational impact of the compensable injury, occupational disease or fatality.

3. To provide reassurance encouragement and counselling to help the worker maintain a positive outlook and remain motivated toward future economic and social capability.

The objectives of Vocational Rehabilitation Services are met by providing the following services to its clients:

- counselling
- vocational assessment and planning;
- job readiness/skill development;
- placement assistance; and
- residual employability assessment.
These services are provided to clients through Vocational Rehabilitation Consultants (‘VRC’). VRCs are also involved in assessing employability for permanent disability and for temporary partial disability under sections 23(3) and 30(1) of the Workers Compensation Act.

1.2 Medical Services

Section 21(1) of the Workers' Compensation Act provides that health care shall be subject to the direction, supervision and control of the board. Questions as to the necessity, character and sufficiency of the health care to be provided will be determined by the board. In general, the WCB's approach is to hold the treating doctor or practitioner responsible for the client's treatment while acting as an advisor to ensure that the practitioner is aware of all the treatment options.

While the WCB has the authority to direct, supervise and control the treatment of an injured worker, the worker is allowed free choice of the physician or practitioner who will provide the treatment. Section 56 of the Act sets out the duties of the physicians and qualified practitioners treating injured workers. Section 57 specifies the WCB's authority to require an injured worker to be examined, as well as allowing the WCB to reduce or suspend compensation if a worker declines essential treatment or performs acts which retard his or her recovery.

The traditional role for Medical Services has been to provide sound, high-quality independent medical advice in a timely manner. Medical Advisors conduct examinations, opinions and work site visits. Medical Advisors in Service Delivery Locations and Area offices also provide advice to Claims Adjudicators and Vocational Rehabilitation Consultants on medical matters related to claims. Medical Services staff are responsible for the evaluation of permanent functional impairment as part of the disability pension award process. Members of the Department also supervise the physical rehabilitation of injured workers. Medical judgements can be reviewed by the Workers' Compensation Review Board, the Appeal Division and Medical Review Panels.

With the move toward case management, the role of Medical Services staff is changing. While some of the functions listed above remain, the Medical Advisors’ role, according to the Board, ‘has been transformed to that of clinical care facilitators, working together with the external medical community to ensure optimum care for their shared client.’ The focus today is less on entitlement determinations and more on facilitating good clinical service within the larger medical community. In this role, Medical Advisors are now supported by Nurse Advisors, a position introduced in spring 1997.

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

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

The 1996 Compensation Services Division business plan established four corporate strategic directions for the Medical Services Department.

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

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

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

- **Community Confidence:**
  - to liaise with BCMA and UBC.

1.3 **Psychology Department**

Although the terms ‘psychology’ and ‘psychologist’ do not appear in the Workers’ Compensation Act, we are advised that the Psychology Department works under Sections 21(1) and (6) and Section 56 of the Act. The term ‘personal injury’ is interpreted to include psychological as well as physical problems.

The Psychology Department was established twenty years ago. Its original function was consultation on cases where psychopathology was evident and where malingering was suspected. Since 1993 there has been an increase in the demand for and range of services. The Department’s current mission statement states:

The Psychology Department will serve workers, employers and the WCB by providing accurate psychological diagnosis services, effective intervention, education and responsible consultation for quality rehabilitation as well as workplace injury prevention. The provision of psychological services is guided by the highest professional principles.
Psychologists and psychometrics within the Department have both a medico-legal role and a counselling role. For example, they may advise claims adjudicators and rehabilitation consultants on the psychological effects of an injury, or departmental staff may conduct aptitude or personality testing of workers to assist rehabilitation consultants develop return to work strategies.

In addition to its services to claimants and other Board staff, the Department is contributing through its research to an international dialogue on susceptibility to both injury and long-term compensation. The Department employs a biopsychosocial model for assessing client health status. Such a model moves the treatment of clients beyond the forensic, or medical models into a more holistic model that recognizes the multiplicity of factors that determine well-being.

1.4 The Leslie R. Peterson Rehabilitation Centre

The Leslie R. Peterson Rehabilitation Centre is located in Richmond, BC and operates pursuant to Sections 16, 21 and 56 of the Workers’ Compensation Act.

The Centre’s Vision Statement reads:

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

The Centre aims to meet its vision by:

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

The Centre’s Statement of Core Values and Beliefs says:

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

We see workers and employers as central to the process of rehabilitation.

We believe that continuous improvement, which is central to our mission, implies ongoing clinical research, program evaluation, and innovation.

Traditionally, the Centre has provided direct rehabilitation services to WCB clients, particularly specialized treatment services not readily available elsewhere, and high quality assessments of clinical conditions and functioning as it relates to employment, and to facilitating re-employment of workers experiencing significant barriers to returning to work. It operates eight interdisciplinary clinical programs:

- **Work Conditioning**
  provides early reactivation and general conditioning.

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

- **Interdisciplinary Pain**
  provides treatment for clients with chronic pain.

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

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

- **Hand**
  provides treatment for clients with acute or chronic hand/wrist injuries.

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

- **Functional Evaluation**
  assesses clients ability to return to work, and provides related education and counselling.

The different interdisciplinary teams could include specialists from: physical therapy, occupational therapy, medicine, psychology, vocational evaluation, vocational rehabilitation, and nursing.

The Centre also has several resources serving these programs: industrial workshops, a residential facility and a health unit. The Program Evaluation and Research Unit (PERU) works with management and staff to develop performance measurement reporting.

Recently, the Centre’s traditional role has undergone a transformation from provider of services to manager of a province-wide network of service providers. As a provider of services, the
Centre was a virtual monopoly, providing the only outpatient multidisciplinary rehabilitation service available to the Board. Over the past two or three years it has evolved into an innovator of treatment service, implementer of a province-wide network of programs and overseer of external programs. Currently it monitors some 140 external programs. As a consequence, injured workers are able to receive treatment closer to home provided by independent health-care professionals working in a competitive environment. The Centre continues to provide services directly, but to a much smaller population.

1.5 Human and Financial Resources

Exhibits 1 and 2 show, respectively, the staffing levels and financial resources allocated to rehabilitation activities. Exhibit 3 shows staffing levels by position for the various Service Delivery Locations (SDL’s) as of December 1997. Data for Vocational Rehabilitation was not provided for 1994. The research team also questions the accuracy of the Vocational Rehabilitation figures for the remaining years.

Exhibit 1
Rehabilitation Departments: Staffing Levels
(Full-time Equivalent Months)

<table>
<thead>
<tr>
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<td>VOCATIONAL</td>
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<td>362.4</td>
<td>546.2</td>
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<td>MEDICAL</td>
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<td>932.2</td>
<td>760.9</td>
<td>592.0</td>
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<td>PSYCHOLOGY</td>
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<td>250.2</td>
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<td>REHAB CENTRE</td>
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<td>3391.4</td>
<td>3054.7</td>
<td>3124.0</td>
<td>2,992.0</td>
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Source:
All data from reports V-Sumdet except
· 98 budget FTEM’s: 98 Business Plan Summary of Resource Plans, ROLL_UP.XLS Resource Summary
### Exhibit 2
Rehabilitation Departments: Financial Resources

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<td><strong>Total</strong></td>
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<td><strong>Total</strong></td>
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<td>23,945,904</td>
<td>23,674,246</td>
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**Note:**
- Capital includes expenditures over $1,000; all other expenses are included in operating expenditures

**Source:**
- All data extracted from reports V-Sumdet, except:
  - 98 Medical Services, Rehabilitation Clinic and Psychology: report B_EXPDET
  - all 98 capital expenses: report B_CAP_SC
  - 87 Rehabilitation Clinic: report B_EXPSUM
Exhibit 3
Rehabilitation Departments:
Full-time Equivalents by Position by Service Delivery Location
As of December 1997

<table>
<thead>
<tr>
<th>SDL</th>
<th>Vocational Rehabilitation Consultants</th>
<th>Vocational Rehabilitation Coordinators</th>
<th>Medical Advisors</th>
<th>Nurse Advisors</th>
<th>Medical Secretaries</th>
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<td>Victoria</td>
<td>6</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>3</td>
</tr>
<tr>
<td>Terrace</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Cranbrook</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kamloops</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Kelowna</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Prince George</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Nelson</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Vernon</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Abbotsford</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>SDR East</td>
<td>16</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SDR West</td>
<td>16</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>76</td>
<td>9</td>
<td>9 (excl Vic)</td>
<td>1 (excl Vic)</td>
<td>14</td>
</tr>
</tbody>
</table>

2. FINDINGS AND CONCLUSIONS

In this section we present findings and conclusions in different ways. First we summarize and compare the overall findings for the four programs. Second we address the general questions presented in the introduction and which the research is intended to inform. Third we present some issues that cut across all the programs. This is followed by a summary of conclusions for
the specific programs. The detailed findings and evidence to support the hypotheses are presented by program in Appendices 4 to 7.

2.1 Findings by Hypotheses and Evaluation Criteria

Eleven hypotheses supported by a total of 48 evaluation criteria were used to direct the research into the way the WCB of BC fulfils its rehabilitation mandate. These hypotheses and most of the criteria stem directly from the Auditor General’s accountability framework. The remaining criteria stem from the CCAF attributes.

Exhibit 4 summarizes our findings on the hypotheses and criteria for each program area. The findings presented here are based strictly on the evidence reviewed by the team. Despite the scope of our research, there are still areas where the researchers felt there was insufficient evidence to draw a conclusion on a specific criterion.

Exhibit 4
Summary of Findings by Hypotheses/Criteria by Program Area

<table>
<thead>
<tr>
<th>Hypotheses/Evaluation Criteria</th>
<th>Voc Rehab</th>
<th>Medical Services</th>
<th>Psych</th>
<th>Rehab Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The division’s mandate is relevant and the division knows what it is supposed to be doing</td>
<td>✓</td>
<td>P</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>1.1 purpose (mandate, mission, goals/objectives) are clearly stated</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>1.2 the program makes sense in light of the conditions to which it is intended to respond</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>1.3 measurable, outcome-focused targets have been established for long-term goals/objectives</td>
<td>P</td>
<td>P</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>1.4 there is a logical, plausible link between mandate and goals/objectives</td>
<td>✓</td>
<td>?</td>
<td>✓</td>
<td>P</td>
</tr>
<tr>
<td>1.5 goals/objectives reflect/are cognizant of the challenges the Division faces</td>
<td>✓</td>
<td>P</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
2. The division has established a strategy to achieve its objectives

<table>
<thead>
<tr>
<th>2.1 intended performance is clearly established through effective planning processes</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 planning at the Division level is done in the context of the entire WCB; i.e. there is a comprehensive system of strategic direction</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>✓</td>
</tr>
<tr>
<td>2.3 management processes are integrated and consistently focused on key aspects of performance</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>✓</td>
</tr>
<tr>
<td>2.4 the focus at all levels is on intended and actual performance</td>
<td>P</td>
<td>✓</td>
<td>P</td>
<td>✓</td>
</tr>
<tr>
<td>2.5 objectives and plans are tailored to meet the mandate within resource allocations</td>
<td>✓</td>
<td>?</td>
<td>P</td>
<td>✓</td>
</tr>
<tr>
<td>2.6 adequate funds and staffing are dedicated to the process to ensure success</td>
<td>?</td>
<td>?</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>2.7 the plans clearly communicate the standards of service clients (workers, employers) should expect when accessing rehabilitation programs</td>
<td>✓</td>
<td>✓</td>
<td>P</td>
<td>✓</td>
</tr>
<tr>
<td>2.8 the design of the program and its major components, and the level of effort being made, are logical, given the objectives to be achieved</td>
<td>?</td>
<td>?</td>
<td>P</td>
<td>✓</td>
</tr>
</tbody>
</table>

3. The structure of the division is appropriate to achieve its objectives

| 3.1 rationale for current structure makes sense | ✓ | M | M | ✓ |
| 3.2 roles and responsibilities are clear and well-integrated | P | M | ✓ | M |
| 3.3 lines of accountability are clear: there are clear and unequivocal mandates that assign tasks, confer powers and identify who is responsible for what | P | M | ✓ | P |
| 3.4 the necessary delegations of authority and decision-making have been made | P | M | P | P |
| 3.5 these responsibilities etc. are communicated | P | M | P | P |
and well-understood

<table>
<thead>
<tr>
<th>4.</th>
<th>The division provides an appropriate work atmosphere</th>
<th>P</th>
<th>M</th>
<th>M</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>the Division provides an appropriate work atmosphere for its employees, provides appropriate opportunities for development and achievement, and promotes commitment, initiative and safety</td>
<td>P</td>
<td>?</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>5.</td>
<td>The division has established and is implementing strategies to measure and report on the extent to which it is achieving its objectives</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>✓</td>
</tr>
<tr>
<td>5.1</td>
<td>the Division has identified, monitors and reports regularly and accurately the key items that are crucial for accountability (success/failure)</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>✓</td>
</tr>
<tr>
<td>5.2</td>
<td>performance measurement is appropriate; it must not be too cumbersome, not involve an inappropriate amount of resources nor take too long so that information is not timely</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>✓</td>
</tr>
<tr>
<td>5.3</td>
<td>the indicators used actually measure performance and organizational strength (i.e. they are meaningful)</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>✓</td>
</tr>
<tr>
<td>5.4</td>
<td>performance information is provided on a timely basis so that results can be used in other management processes (planning, budgeting)</td>
<td>✓</td>
<td>P</td>
<td>P</td>
<td>✓</td>
</tr>
<tr>
<td>5.5</td>
<td>measured outcomes and impacts/findings are used to ensure increasingly limited resources are used in a more/the most relevant, economic and effective manner</td>
<td>P</td>
<td>?</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5.6</td>
<td>government provides fair, reliable and timely reporting about the intended and actual results for all key aspects of its performance to all interested parties</td>
<td>P</td>
<td>P</td>
<td>?</td>
<td>✓</td>
</tr>
</tbody>
</table>
5.7 reports present data/information and analysis that is accurate, reliable, consistent, complete, meaningful, timely, replicable, impartial and that states assumptions used  & P & P & ? & ✓ \\
5.8 reporting is subject to verification/audit  & P & P & ? & ✓ \\
5.9 performance information is the basis on which decisions are made  & ? & ? & ✓ & ✓ \\
6. The division is achieving its objectives  & ? & P & ✓ & ✓ \\
6.1 the Division is achieving what is set out to do  & ? & P & ✓ & ✓ \\
6.2 the programs/services the Division delivers are relevant  & M & ✓ & ✓ & ✓ \\
6.3 the constituencies to which the programs/services are directed judge them to be satisfactory  & M & ? & ✓ & ✓ \\
6.4 the Division is able to identify secondary impacts and eliminate those that are negative, and build upon those that are positive  & ✗ & ✗ & ✗ & ✓ \\
7. The division is achieving its objectives in a cost-effective way  & ✗ & ✗ & P & ? \\
7.1 the Division is able to identify costs, inputs and outputs and determine the relationship between them  & ✗ & ✗ & P & P \\
7.2 the Division conducts the necessary analyses to determine if it is achieving its results at a reasonable cost (i.e. is efficient and economical)  & ✗ & ✗ & P & P \\
8. The division is determining future needs and maintaining the capacity to deliver results in the future  & ✓ & P & P & ✓ \\
8.1 the Division has the ability to maintain or improve results  & P & ✓ & ✓ & ✓
8.2 the Division has identified the capacity (staff, external contractors etc.) to deal with the future, so that it is protected from the danger of losses that could threaten its success, credibility and continuity

| 8.2 | ✓ | ✓ | P | ✓ |

8.3 the Division is positioned to adapt to changes in such factors as markets, competition, available funding or technology

| 8.3 | P | P | P | ✓ |

9. The division has set and is achieving its financial objectives

| 9 | ✓ | P | P | P |

9.1 the Division has set financial objectives

| 9.1 | ✓ | ✓ | P | P |

9.2 financial objectives are cognizant of and developed using the measurement of actual performance (i.e. performance information is the basis on which financial decisions are made, OR: performance measurement has a direct impact on budgets)

| 9.2 | P | P | ✓ | P |

9.3 the Division keeps complete and accurate financial records and can account for revenue and expenditures, and for the valuation of assets, liability and equity

| 9.3 | ✓ | ? | P | P |

9.4 the Division determines and reports on a regular basis whether its financial objectives are being met

| 9.4 | P | ? | P | P |

9.5 the Division takes the steps necessary to address any variances identified

| 9.5 | P | P | ? | P |

9.6 the Division manages its financial responsibilities according to sound financial controls

| 9.6 | P | P | ? | P |

9.7 the financial information is subject to verification/audit

| 9.7 | ✓ | ? | ? | P |

10. The division is protecting its assets

| 10 | ✓ | P | M | ✓ |
10.1 important assets are safeguarded so that the Division is protected from the danger of losses that could threaten its success, credibility, continuity and existence

| 10.1 | ✓ | P | M | ✓ |

11. The division’s affairs are conducted in accordance with legislated requirements and with expected standards of conduct

| 11. | ✓ | M | ✓ | ✓ |

11.1 the Division is responsible for complying with legislation and related authorities

| 11.1 | ✓ | ✓ | ✓ | ✓ |

11.2 the Division is conducting its business with fairness, equity and probity

| 11.2 | M | M | ✓ | ✓ |

11.3 while achievement of results is important, the manner in which results are obtained is also important. The public expects the Board to be fair and ethical in the delivery of its programs

| 11.3 | P | M | ✓ | ✓ |

Legend:
- ✓ either fully or generally met
- P partially met
- M mixed evidence: some supporting, some opposing
- × not met
- ? Insufficient evidence either way to determine if met or not

The table shows a fairly high degree of consistency across the departments in many areas, with the Rehabilitation Centre outperforming the three other programs. Much of this outperformance is likely attributable to the existence of the Centre’s Program Evaluation and Research Unit, and the value Centre management place on its research.

Few problems were encountered in the areas of mandate, mission, objectives and planning. Improvements have been tracked over time and to a large extent, the documents reviewed meet most of the guidelines set by the Crown Corporations Secretariat of BC for planning documents. Some of the programs could benefit from more outcome oriented and timebound objectives against which the impact and effectiveness of their work could be assessed.

Strategies to implement program mandates and objectives have been designed. Detailed manuals, handbooks and protocols have been developed to guide the day-to-day work of practitioners.

Performance measurement of internal activities has improved over time and the programs are increasingly in a better position to determine changes in their performance year over year.
The Rehabilitation Centre and, to a lesser extent, Psychology, are in a good position to determine outcomes attributable to their activities and improve their services accordingly. The Centre, however, is the only one of the four programs reviewed that can identify secondary impacts and eliminate those that are negative. The absence of reliable management information has far-reaching implications in terms of services offered, resource requirements and resource allocation.

The current structure for delivering services — Vocational Rehabilitation as part of Compensation Services Division, and the other three programs in a separate Division, with both divisions reporting to the same vice president — appears suitable to most of the groups working within it. There is some dissent, however, among both management and staff. There is also a lot of concern, primarily among staff, but for some managers too, with recent changes in the physical surroundings within which all RCS Division staff have to work. These changes have been described as counterproductive.

Identifying program resources, both human and financial, proved somewhat difficult. Public documents such as business plans have improved over time. Nevertheless, it is not always easy to track resources from year to year, in part due to changes (mostly improvements) that have occurred over time. Even at the detailed level of the Service Delivery Locations, data may be incomplete or reported in slightly different ways, bringing into question their comparability.

Budgets, which the Board considers its financial objectives, are set and reported against in business plans. Variance reporting could benefit from some additional analysis.

The Rehabilitation Centre has made some attempts to conduct cost effectiveness analyses. Psychology has compared the costs of internal versus external provision of services. As the Board does not allocate all expenses across programs, these analyses are not fully representative. Vocational Rehabilitation and Medical Services are not in a position to determine their cost effectiveness.

For the most part, programs are protecting their assets, which include not only physical and financial assets but also staff, external suppliers and data.

In any organization as large as the Board and with the discretionary nature of many of the activities reviewed, there is potential for inconsistency in application of policies, and for some level of dissatisfaction among stakeholders. The potential for dissatisfaction is relatively high for the programs reviewed, given the client population with which they deal. Program clients are injured workers who are not working. Some of them will not be able to work again, at least not in the jobs and at the level they had at the time of their injuries. Some of them are in constant pain or in stressful situations. Satisfaction levels among clients of the Rehabilitation Centre and Psychology are relatively high. They are lower among clients of Vocational Rehabilitation and Medical Services. The Board itself is determined to improve its satisfaction ratings among clients.

The Board is already aware of most if not all of the concerns identified through the research and in many cases has plans to address them. Several initiatives are underway.
The findings of the research team are similar to those presented in the Auditor General’s Accountability Reporting Review, January 1998. The Auditor General’s review is also based on the accountability framework and the 12 attributes of effectiveness.

2.2 Findings by Questions

The introduction to this report presented six questions that the research is intended to inform. This section presents findings relating to those questions.

2.2.1 Are the right people receiving rehabilitation services?

Not every injured worker needs help returning to work. Nor do they all need clinical rehabilitation. The criteria used by the Board to determine need for these services appears to be based on experience, rehabilitation practice in general and research.

Some interviewees noted that there are certain groups who could perhaps benefit by being offered services or a different range or depth of services. Client surveys, submissions to the commission and appeals indicate that some people think they did not get the services they should have received. However, the number of cases in the overall picture appears relatively small.

The research team concludes that for the most part, rehabilitation services are delivered to those most in need and who can benefit from them.

2.2.2 Are they receiving the right services?

Only the Rehabilitation Centre consistently evaluates its services to address this question. The answer in this case appears to be yes. Service protocols are based on research and the results of outcome evaluations.

The Psychology Department is contributing to international research on the relationship of psychological services, workplace injury and compensation. Considered by some to be a leader in this area, it is likely that the Department is providing the best services based on current research. However, the relationship between outcomes and the services provided is not rigorously and consistently tested and the Department itself recognizes limitations with assessment tools and practice.

Vocational rehabilitation outcomes are clearly stated as return to work; however, there has been little analysis of the relationship between services provided and results. The services offered are consistent with those offered by other organizations with similar mandates, and are more generous than those found in some jurisdictions.

The role of Medical Services has changed quite significantly over the last year or so. The Board itself found the services traditionally provided by its Medical Advisors to be somewhat inappropriate. It is too early to determine whether the new model will result in the right services being offered. Until specific client-oriented outcomes are set for these activities, it will be
impossible to measure the effectiveness of the activities put in place to bring about those outcomes.

2.2.3 Are these services provided in an appropriate way?

The professionalism of staff at the Board appears to be generally high. The manuals, handbooks and protocols designed to guide program implementation appear appropriate. In many instances they state the underlying principles on which services are based and these also appear appropriate.

Client satisfaction has been measured consistently and for some time for services provided by the Rehabilitation Centre and Psychology Department. Within the Rehabilitation Centre, satisfaction varies from program to program, but is generally high and seems to be increasing or maintained over time. In Psychology, clients indicate an overall satisfaction rating of 92% compared with the standard of 85% set by the industry.

Client satisfaction regarding vocational rehabilitation services has not been measured consistently in the past. Efforts are underway to correct that situation. The information that is available suggests a higher level of dissatisfaction among VRS clients than among the clients of the Rehabilitation Centre and Psychology Department.

Satisfaction among the clients of Medical Services has been measured at specific points in the past. Results were variable.

We conclude that while the delivery of most services, particularly in the Rehabilitation Centre and Psychology, is likely appropriate, there is significant room for improvement in other areas. The poor results of some of the data relating to Medical Services contributed to the change being implemented in the role of the Medical Advisor.

2.2.4 Are these services as useful as they could be?

The research did not identify any national or international benchmarks against which to measure the Board’s outcomes. Given the differences between the various jurisdictions, it is not clear whether such benchmarks would in fact have much meaning. Thus, the only way in which this question can be answered is to compare results by program, year over year.

Some of the services provided through the Rehabilitation Centre appear to be fairly successful in helping injured workers return to work and to stay at work. For example, for three of the six programs for which data are kept, upward of half of the persons who returned to work at discharge were still working three months after discharge, and this rate is achieved year after year.

Vocational Rehabilitation Services captures return to work through its closure codes. Statistics presented by the Board suggest that there is improvement in returns to work for those workers referred for whom a return to work was a realistic outcome. There are, however, major concerns regarding the data base, concerns which the Department itself recognizes. Follow-up interviews
with workers who returned to work are not conducted; thus the durable and safe aspects of return to work are not known.

Client outcome data are not collected or reported by Psychology and Medical Services.

The lack of reliable management information that tracks outcomes and examines their attribution makes it difficult, with the exception of the Rehabilitation Centre, to determine whether services are as useful as they could be.

2.2.5 Are these services delivered in a cost-effective way?

The Board does not allocate overheads on a program basis; thus it is impossible to identify the full costs involved in delivering the programs.

Psychology and the Rehabilitation Centre have identified the costs associated with their particular programs. The Rehabilitation Centre also identifies outcomes by program and has conducted some cost benefit analyses. These two programs are fairly well positioned to compare the cost-effectiveness of providing services internally versus externally.

Medical Services and Vocational Rehabilitation do not have the necessary information to determine their cost effectiveness.

2.2.6 What improvements could be made or pursued, at what cost?

Rehabilitation Services in general:

• Avoid further major changes.
• Consolidate the changes that have occurred.
• Complete the initiatives underway, particularly e-file, case management and data warehouse.
• Proceed with activity-based costing to enhance the ability to determine cost effectiveness.
• Address the safety concerns of staff.
• Address the issues staff have raised concerning their physical work environment.
• In the business plans include additional analysis of variances between budget, forecast and actual figures.

Vocational Rehabilitation Services:

• Define durable and safe return to work.
• Complete the transition of data collection from the RPM to the e-file to ensure an accurate, complete and reliable data base in the future; identify positions responsible for data input; train staff and implement.
• For all clients for whom return to work is a realistic outcome:
  • collect and report accurate data on the return to work status of individuals (as opposed to claim files);
• collect data on individuals at the 3 month after return to work date.  
• For a randomly selected sample of clients who have returned to work:  
  • collect data on individuals at the 6 month and 12 month after return to work dates.  
• Complete the evaluations currently underway on formal training and business start ups;  
  examine the results carefully and determine the effectiveness and usefulness of these  
  interventions.  
• Evaluate the remaining services; examine the results carefully and determine the  
  effectiveness and usefulness of these interventions.  
• Examine the results from activity-based costing, the evaluations of individual services  
  and the follow up data in the framework of vocational rehabilitation services as a whole  
  to determine which services are the most effective for which types of clients.  
• Produce monthly outcome figures and post these in locations where all VRCs can see  
  them (following the example of the Rehabilitation Centre).  
• Hire a staff person to conduct labour market and economic analyses on behalf of the  
  Department and make this information available to all VRCs on a regular basis.  
• Prepare job descriptions for the director and senior manager positions.  
• Institute a communications systems among all departmental staff that is consistent and  
  inclusive.  
• Conduct a regular and systematic analysis of appeals that revolve around vocational  
  rehabilitation issues to determine where the problems occur and how they may be  
  avoided in future.

Medical Services:

• Identify the intended outcomes for clients. This means answering such questions as:  
  • what is the purpose of conducting medical opinions, examinations and worksite  
    visits?  
  • how are these activities intended to benefit injured workers?  
  • how are these activities intended to benefit other stakeholder groups such as  
    employers, the medical community?  
• Measure the actual outcomes for clients and determine attribution. For example:  
  • what are the results of worksite visits?  
  • have they contributed to more workers returning to their injury employer?  
  • have they contributed to a decrease in re-injury after a return to work?  
• Ensure that the medical community at large is aware of Board requirements and  
  expectations through the thorough dissemination of such documents as the Attending  
  Physician’s Handbook.  
• Review the working relationship between the revised role of the Medical Advisor and the  
  relatively new role of the Nurse Advisor to ensure the two are complementary, and are  
  working in practice as intended.  
• Establish a baseline for client satisfaction with the revised role of the Medical Advisor,  
  and measure satisfaction periodically over time so that changes can be examined against  
  the baseline. In measuring satisfaction, take steps to ensure that factors such as emotional  
  and physical trauma are properly accounted for.
Psychology:

- Address the tensions created among staff that have resulted from inclusion of the Department within the Rehabilitation Division.
- Address the issues resulting from changes to psychologists’ physical work sites. This includes ethical and safety issues.
- Clarify referral policies and ensure they are understood by all persons likely to make referrals.
- Identify the intended outcomes for clients. This means answering such questions as:
  - what is the purpose of the medico-legal role, and the assessment role?
  - how are these activities intended to benefit injured workers?
  - how are these activities intended to benefit other stakeholder groups such as employers, the medical community?
- Measure the actual outcomes for clients and determine attribution. For example:
  - what are the results of assessments, and counselling?
  - have they contributed to more workers returning to work or being ready for other rehabilitation services?
- Clarify the policy for using external service providers. Ensure their use is cost-beneficial. Ensure that adequate contract arrangements are in place and that the policy and contracting arrangements are fully understood by staff.

Rehabilitation Centre:

- Ensure staff roles and reporting relationships for both administrative and professional purposes are fully understood by incumbents.
- Ensure that the lines of accountability and responsibility for data management between PERU and the IS Department are clear and understood by those working in both areas.

Costs:

The costs involved in each of the above steps are not huge. In many instances, it is a matter of making a decision. In some cases, for example replacing the VRS RPM system with a fully-integrated e-file data base, there will likely be cost savings in the long run.

There are costs involved in collecting follow-up data on a regular basis and in conducting effectiveness evaluations. However, the results could lead to a better use of services or improved targeting, which in turn could produce cost savings. The data collection and analysis costs might be kept to a minimum if PERU were to become responsible for the tasks. This would reduce overheads and ensure a quality standard that has been demonstrated over time. If this were to occur, it would be essential that non-Rehabilitation Centre studies be given equal priority as those conducted on behalf of the Rehabilitation Centre.

In other situations, it may be a question of re-aligning tasks within the given resource complement. For example, VRC’s currently have to collect data on the labour market. If one
person does this systematically and circulates the information to all VRC’s, then that part of the VRC’s role is eliminated and they can concentrate on other activities.

2.3 Cross Program Findings

Some findings relate to all or most of the four programs reviewed. They are presented here to avoid repetition.

- The Board has seen an enormous amount of sometimes frenetic change over the period of review. Major changes have occurred in governance, organizational structure, personnel, and delivery methods.

- There was a move to establish a Rehabilitation Division separate from Compensation Services Division, and to include in it all the rehabilitation functions. This was subsequently abandoned. While senior management may be clear about the current structure, not all staff are. Nor is the documentation clear: in some places reference is made to one Rehabilitation and Compensation Service Division, in other documents, they are clearly two Divisions. There is still some debate among the professional staff on the merits of a separate rehabilitation division. The change in structure led to a concomitant change in influence among the programs.

In correspondence with the commission, the Board response commented:

‘The principal advantage of the reconstitution of a Rehabilitation Division was not in the existence of the Division itself but in its integration with Compensation Services. The two Divisions now offer integrated services to injured workers focused on return to work. The two Divisions share the same client group, the same goals and the same philosophy of doing whatever is necessary to promote a timely and safe return to work. As Compensation Services comes to centre more around case management, the logic in having two separate divisions becomes more tenuous.’

- Many new initiatives such as e-file, case management, disability management and performance measurement have been put in train. These affect the delivery of rehabilitation services in both obvious and subtle ways. For example, the Board in correspondence with the commission commented:

‘Half a dozen years ago, both Psychology and Medical Services served primarily as consultants to claims adjudication and Vocational Rehabilitation staff .... this clinical expertise was used primarily to buttress decision-making and to provide a counterpoint to undesired external opinions. This model had as a side effect the creation of an adversarial relationship with the injured workers who quickly came to understand that the Board’s experts existed to overrule their own health care professionals. It also engendered a perception of a bad faith relationship with the
larger medical community, as they saw a group of physicians who frequently overruled the community’s clinical judgement.

‘With the anticipated advent of case management, the Board Medical Advisors’ role has been transformed to that of clinical care facilitators, working together with the external medical community to ensure optimum care for their shared client .... The transformation of the Psychology Department is intended to parallel that of Medical Services ...’

In most instances, it is too early to determine the impact of these initiatives on rehabilitation programs and outcomes.

- Rehabilitation, particularly vocational rehabilitation, has been the focus of several administrative inventories and follow-ups. Some of the changes apparent at the Board appear to be direct responses to the attention points identified in the inventories.

- Planning has become a regular part of the annual cycle at the Board. With each year, the planning process is becoming more refined. The Corporate Controller’s office provides program managers with annual budget guidelines and targets. In 1997, this manual included the business planning and approval process, the budgeting schedule, the budget rules, general ledger budget accounts, the operating budget targets, and the budget module.

- While some goals and objectives are clearly stated, there seems to be a move towards Critical Success Factors in place of objectives. CSF’s appear to be less rigorous than measurable, time-bound objectives.

- The programs are becoming more outcomes oriented. However, apart from the Rehabilitation Centre, there is no definition of the major outcome ‘durable and safe return to work’. This is a fundamental flaw in the measurement of outcomes.

- The Rehabilitation Centre aside, managers and staff alike noted a lack of management information and adequate systems. ‘The Board has lots of data, but no information.’ For example, a report prepared by Psychology staff states that a substantial body of empirical literature supports the assertion that factors other than the injury itself may determine the eventual outcome of workers’ injuries. Data on many of these factors such as sociodemographic data, clinical information, job- and employer-related data are routinely recorded with workers’ claims and are accessible for analysis. Our review, however, shows that that analysis is seldom done.

According to the Vice President, the RCS Division does not know the mix of clients, trends by geographic region or by desk. It has to wait for monthly, bi-annual or annual statistics; this does not allow the Division to respond as quickly as it needs to.
• The review of the Administrative Inventories conducted for the commission notes: Activity measures alone (e.g. number of inspections, orders, etc.) are not sufficient indicators of performance; nor are outcome measures linked only to reductions in claims. The area of performance measurement needs critical examination and attention; reliance on faulty or insufficient measures can only damage the WCB in the long run.

• Historical investments in technology have resulted in data being placed in individual ‘silos’. There are problems with data fragmentation, data quality and data availability.

• Internal Audit’s 1997 Report on Significant Issues confirmed that ‘Management information issues contributed to a significant number of problems identified in Internal Audit reports in 1996 and previous years. This results from data which in some cases are: not accurate, not captured in a timely fashion, not well-defined at the Board, captured in multiple places or not consistent, captured in some but not all cases, or not captured at all.’

• The use of third party providers has forced the Board to develop performance and accountability measures for contractors. This has had a spill over effect with internal staff.

• The Board does not have activity-based costing. The Division is currently working on identifying all costs related to a claim (part of the Data Warehouse project). This involves pulling data from the different systems such as AWL (wage loss), pensions and health care. While it is currently possible to do this on an ad hoc basis, it is not done routinely. This problem should be resolved through increment 2 of the Data Warehouse project, which will also include vocational rehabilitation expenses. Until that time, the Board is not in a position to track expenditures related to an individual. It can only identify costs related to a specific claim.

• Once the Board or Division is in a position to capture all direct costs (‘fully loaded costs’) associated with its activities, it will be in a much better position to examine its cost effectiveness. Meanwhile, cost effectiveness is considered ‘informally’ as part of the budgeting process. Questions posed include how are resources going to change from year to year, and how are outcomes and work volumes expected to change. There are no precise formulae.

• Rehabilitation services are provided through a matrix form of administration, in which some staff receive their administrative supervision from one source, and their functional (professional) guidance from another. It is not clear if the matrix arrangement is complete or whether it relates only to parts of these services. Some minor confusion regarding lines of authority was apparent among staff interviewed.

• It has proved generally difficult to get a grip of the number of staff. This is further complicated by the matrix organization within which the Board operates. It is not, for example, simply a matter of counting the names on organization charts: the same name
may occur on different charts, because the position reports to one section or department for administrative purposes and to another for clinical/professional purposes. Also, the same name may occur more than once on one organization chart, depending on the way responsibilities are distributed.

- Staff morale appears to have improved since its nadir in 1995. However, the Board recognizes that it is not yet at an acceptable level and likely will not be until all the changes currently underway are in place and staff can see how those changes affect them individually.

- Staff and management (both those who participated in the open meetings and others spoken to both formally and informally) indicated a high level of dislike and fear of the Divisions’ vice president. This permeates the workplace, generates a significant degree of lack of trust, lack of security and deep anxiety, and ultimately affects productivity.

- Staff and some management expressed a strong dislike for changes in the physical work environment. The removal of all the offices in the Richmond headquarters and their replacement with open cubicles was intended to foster the team approach to service delivery. According to many interviewees, it has had exactly the opposite effect, primarily because of increased noise levels and lack of privacy. The move is seen by many as dehumanizing. For professional employees, the lack of privacy is an ethical issue that prohibits them dealing with clients in the manner in which they have been trained.

- Board employees interviewed noted that many issues raised through interviews and during the commission hearings have been raised by them frequently, in some cases over as many as 15 years. In their view, management does not listen, preferring to implement huge initiatives, rather than make the necessary but relatively minor amendments to existing practices. Consequently, employees with field experience feel ignored. A frequent comment during interviews was ‘We work in spite of, not because of, management.’

- There are real safety concerns among staff. While there are panic buttons in the individual interview rooms, these rooms are some distance away from other work areas and staff are reluctant to use them when they have clients who may possibly be dangerous.

- Assets such as buildings, equipment, the physical plant and investments fall within the purview of the Corporate Controller. At this level, staff are not considered an asset: they are a managerial responsibility.

- Treasury Department is responsible for tracking and safeguarding physical assets. Capital items such as furniture are assigned to a department, which is responsible for the security of those items. Information Systems Department is responsible for computers,
equipment and software. As all Board computers are in networks, ISD can track and control remotely the software that each unit has on its system.

- At the Division level, management do include staff as an asset. Protection of the physical safety of staff and their personal belongings on site is a function of management, as is ergonomic protection. The Board tries to ensure that staff have the right equipment and tools to do the job. Staff are also covered by insurance.

- The Division also considers data as an asset. The Divisional Controller is the data guardian for the Division; as such he has to approve access for Compensation Services staff to data. The Manager, Finance and Administration, has the same responsibility within Rehabilitation Division. This not only protects the Board’s data, it protects those staff who do have the appropriate access to data.

- External suppliers are covered by contracts. If they are consultants working in a WCB building, they are covered by the same security measures as Board staff.

- The WCB has published standards of conduct. The document states that the examples and statements contained in it flow from principles of honesty, impartiality, and ethical behaviour. The standards are to apply to all employees and contractors who may also be governed by professional codes of ethics or conduct. Specific topics discussed include: relatives, personal, business or financial interest, outside remuneration, gifts and benefits, whistle-blowing, appeal commissioners, conflict of interest inquiry, good faith or inadvertence, and violation of policy.

2.4 Summary Conclusions by Program

2.4.1 Vocational Rehabilitation Services

Based on the evidence reviewed, the research team concludes that the Vocational Rehabilitation Department generally meets seven of the eleven hypotheses, although certain criteria within these hypotheses may not be fully supported by the evidence.

The Department’s mandate, mission and objectives are clearly stated and well documented. Return to work is very clearly the objective of vocational rehabilitation services.

The Department has been a leader in the area of planning, and the strategies currently being pursued appear to support the objectives.

Since the Department was reconstituted in 1995, staff morale appears to have improved and the workplace has become more stable. Professional development has become a focus for departmental management. However, some staff believe that there are many issues, some of them long-term, that are outstanding. These focus primarily on how the VRC is perceived within the Board.
The Department does appear to be maintaining if not improving its results, although the reliability of the data on which this conclusion is based is questionable. The Department also appears to be fairly well positioned to continue to meet future challenges. For example, it is seeking to enhance the professional development of its internal staff, to improve its third party provider network, and to remain up to date with major initiatives within the Board, such as e-file.

The Department budgets for program costs and for administrative costs. Program costs, however, are determined by the professional staff based on the actual vocational rehabilitation needs of individual clients. In recent years, the Department has stayed within budget for both program and administrative areas. The coding and tracking of expenditures appears to be improving over time. Explanations for changes, for example, in coding and for variances could be improved.

Assets within the Department’s purview appear to be generally protected. In particular, procedures are now in place to protect major assets purchased by the Board on behalf of VRS clients.

Vocational rehabilitation services are discretionary. As long as this situation remains, there will be the potential for actual or perceived unfairness. The research team has been unable to determine the extent of actual unfairness due to a lack of data. For example, appeals are not identified as being related to vocational rehabilitation services and thus there is no regular analysis of related decisions. While departmental staff are bound by the Board’s general standards of conduct, a vocational rehabilitation-specific code of conduct may provide additional safeguards to ensure fairness and equity. Reinstatement of a vocational rehabilitation advisory council or similar body with representation from the different stakeholder groups may also be of benefit.

The research team concludes that three of the hypotheses are partially met or have conflicting evidence.

With respect to roles and responsibilities of staff, the lack of job descriptions for the director and senior managers is disconcerting. Operating within a complex matrix poses enough problems; the lack of job descriptions adds to them. Communications with staff also appears to be problematic.

Inadequacies in the existing management information system have resulted in the research team concluding that hypotheses 5 and 6 are not fully supported by the evidence. Without definitions of safe and durable return to work, and without the results of follow-up surveys of clients, the Department cannot determine whether it is meeting its major objective.

It appears that satisfaction levels among clients could be improved.

The research team was unable to answer one hypothesis. There is insufficient evidence to determine whether the Department is achieving its objectives in a cost effective way. The Board does not currently identify all inputs in such a way that they can be assigned by department.
There are problems with the accuracy of outputs/results. Finally, the relationship between inputs and outputs has not been analyzed.

### 2.4.2 Medical Services

The mandate for the Department is explicit in the legislation, which defines Medical Aid and the Duty of physician or practitioner. The Department’s mission is also documented. However, only a few specific goal/objective statements have been found. Where goals or objectives are available, they often have an activity orientation rather than an outcome orientation. Data on the numbers and timeliness of activities are available. No client-based outcome data has been identified.

The Medical Services Department participates in Divisional planning processes. The definitions and requirements of the various components of these plans could be clarified to ensure logical internal consistency in the documents. It appears that Divisional planning is done in context of the corporate strategic direction. However, the plans have varied over the years in the ease with which the reader can easily and quickly trace the connection between the corporate plan and the Divisional and Department plans.

There is evidence that the Medical Services Department is participating in a variety of interdepartmental initiatives such as case management, e-file, care map, and continuum of care. Although data and objectives are often limited to activity-based measures, there is additional evidence that the Department focuses attention of desirable outcomes in other ways. Clinical practice guidelines have been under development for some time. Standardized assessment forms have been developed for neck and low back pain. Expectations for the Department are discussed in both the *Attending Physician's Handbook* and the *WCB Physicians' Procedure Manual*.

None of the evidence and documentation reviewed by the research team suggested that inadequate funding or staffing was interfering with the Department's ability to succeed or that the level of effort being made was not logical.

The structure of the Medical Services Department is an area that has caused some concern in two areas, role definition and reporting structures.

There are multiple sources of evidence that the role of the Medical Advisor has been or is in the process of being refined. At the same time, the role of Nurse Advisor has been introduced into the organization, no doubt compounding the potential for some ambiguity and confusion. Although the Nurse Advisor role appears to fit within the Board structure and the definition of the role relatively clear in theory, it is anticipated that there will be a period of transition.

The evidence is not clear on who is part of Medical Services, and what exactly they do. Clearly, the Medical Advisors who provide services such as ‘at Board’ exams and are located in Area Offices or Service Delivery Locations are part of the MS complement. It is the activities of these physicians that make up much of the activity measurements for the Department (e.g. timeliness.
of opinions). Also included in Medical Services are those physicians who provide disability award advice (eg. DAMAs) through PFI exams.

The status of three additional groups in Occupational Disease, Prevention and the Rehabilitation Centre is less clear. The evidence did not demonstrate clearly whether physicians are part of a matrix organization.

Physicians have become increasingly involved in WCB service improvement projects. Upgrading technical skills and an increased commitment to research has improved the professional development climate. However, we could not determine the extent of peer reviewed research publications by WCB Medical Staff and generally found very little data on the working environment that physicians at the Board experience. There was no evidence presented to the team to demonstrate the extent to which Medical Services staff have been affected by recent transitions at the Board.

There has been evidence of concern regarding clients' and customers' satisfaction with Medical Services since as early as 1993. This climate of constantly questioning the professional staff's competence and effectiveness could be expected to impact on the work atmosphere but surprisingly no evidence of that nature was discovered.

The development and maintenance of appropriate information systems seems to be an ongoing issue for the Board generally. Inadequate management information is an issue at many levels of the organization including Medical Services. There is no management information system for the Department, and no documentation that one is planned. A limited range of activity-based performance information is available to Medical Services. However, client-based data is not. There are no clinical information systems evidenced, although there is a manual quality assurance process in place. The lack of quality information and appropriate information systems impacts most if not all of the Department’s activities. For example, it is difficult to plan adequately, assess achievements, or prepare for contingencies in an information vacuum.

There is some evidence that the Department is achieving its activity objectives e.g. meeting timeliness goals. There is also evidence that the Department is trying to be proactive. However, because the systems do not exist, the Department cannot determine the impact of its activities on its client population — primarily injured workers and the medical community.

The Medical Services Department has very limited ability to identify relationships between inputs and outputs. There are few examples of cost-benefit analyses available. The difficulty is not so much in identifying outputs but in identifying outcomes. Virtually no client-based outcome data is available to the Department. No definitions of client-based outcome measures or indicators were discovered.

Although concerns have been raised regarding constituencies' satisfaction with Medical Services, this requires careful investigation. How this type of information is collected is critical. Patients experiencing considerable trauma, both emotional and physical, due to a disabling injury could quite naturally direct some of their anger towards caregivers, regardless of the quality of care.
provided. However, the evidence reviewed seems to indicate that client satisfaction is an ongoing concern requiring further attention.

Assessing whether Medical Services' affairs are being conducted in accordance with legislated requirements and expected standards is complex. Many contentious issues requiring ongoing attention impact or directly relate to the services provided by the Department but may yet be outside of the control of the Department. Examples include the ongoing nature of the debate of what constitutes an occupational disease, how functional pension awards can be assessed fairly and equitably, and whether providing expedited service to WCB clients is creating a two-tiered health care system.

Medical Services staff are expected to conduct themselves according to the WCB's standards as well as their own professional standards. Direction is given the staff regarding specific matters such as the protections of confidentiality and requirements under FIPPA.

A significant issue is the perception of whether the Board's physicians are fair and ethical in the delivery of their services. Dissatisfaction has been voiced from several sources including both workers and their advocates and physicians and their advocates. However, one must also take into account that the Board physicians are most likely to see complex cases. The more complex the case, the less likely a patient is to be satisfied with the care or caregiver. Attention is being given to this issue. For example, the redefinition of the Medical Advisor's role is expected to lead to early involvement with patients and a less adversarial relationship.

For Medical Services, medical expertise is a key asset that must be developed to establish the capacity to address future needs. The Department's involvement with UBC and the development of the Undergraduate Medical School curriculum is an excellent example of addressing this issue. The Director of Medical Services also chairs the Technology Assessment Committee which is involved in evaluating health technologies. This is another positive finding. However, Medical Services is again hampered by the limitations of internal information systems and the scarcity of information development (whether that is IS or research) resources. It is difficult to maintain or improve results if you do not know what they are or what affects them.

2.4.3 Psychology

The Psychology Department at WCB was established twenty years ago. Its original function was consultation on cases where psychopathology was evident and where malingering was suspected. Since 1993 there has been an increase in the demand for and range of services. The number of new referrals has increased from 895 in 1990 to 1,228 in 1995 and currently stands at about 1,150. The services offered are: assessment, treatment, crisis intervention, consulting and education.

In addition to its services to claimants, the Psychology Department is contributing through its research, to an international dialogue on susceptibility to both injury and long term compensation. The Department employs a biopsychosocial model for assessing client health status. Such a model moves the treatment of clients beyond the forensic, or medical models into a more holistic model that recognizes the multiplicity of factors that determine well-being. The
department expresses a commitment to the needs of a multi-cultural workforce and identifies itself as a culturally diverse team. Limitations with assessment tools and practice in this area are readily acknowledged in the documentation. Work is underway to address the need for improved service in this area.

The department had operated autonomously and, in the opinion of both members and the related professional associations, with great success for a number of years. The incorporation of the department in 1996 into the new Rehabilitation and Compensation Services Division has created significant tension for several reasons. The Compensation side of the Division is considerably larger than the Rehabilitation side and it is possible that Compensation’s mandate dominates the agenda. Staff have been relocated to a new space where cubicles are the standard work space. This has raised significant confidentiality issues for practitioners and clients. Finally, there are ethical considerations regarding the potential for ‘undue’ influence from the Compensation sector on the assessment process.

The ethical standards for psychologists require them to place clients’ needs above the needs of the institution that employs them. The psychologists are not alone in this conflict. The dual nature of the WCB as a compensation system and health care provider with a public policy interest creates systemic conflict. The department is supported in its motion to remain autonomous by the staff’s professional association. The department did engage in a process to determine their acceptability as a Special Agency. They met three of the six criteria wholly, two partially and one not at all. Had they been successful they would have become a partner to the WCB but quite distinct with respect to funding and program control. This culture of independence, which was fostered during the era of direct reporting to the President/CEO, is under significant stress as a result of the reorganization.

Given the stresses experienced by the Psychology Department, the ongoing threat of job loss and work contracted out, the environment for staff is less than positive.

The department has a very good record with respect to strategic and business planning as well as the creation of performance measurement systems. However, there is considerable work to be done with respect to costing influences other than salaries and equipment. For example, there is no workload measurement system that allows for the creation of productivity measures based on daily activities. There is reference to ‘service unit cost’; however no material on how this number is generated was available to the researchers. The department appears to hold the line on expenditures and lives quite close to its budgeted allowance.

There is a clear perception among departmental staff that the use of external psychologists to conduct assessments is counter-productive to the efficacy and cost effectiveness of the WCB. It is argued that external assessors do not understand WCB policy and therefore internal psychologists are often required to update or act upon incomplete work from an external contractor. Further it is argued that the cost of external contractors is much higher and therefore it is not a cost effective move to contract out more work. Apart from interviews and discussions with staff, the researchers did not receive any material to directly support this claim. This coupled with inequities in pay scales for the Psychology Department contributes to an atmosphere of frustration on behalf of departmental staff.
It is not clear whether the psychologists in the Rehabilitation Centre receive clinical supervision from the Chief Psychologist. There appears to be a matrix organization in which the psychologists report to a Rehabilitation Centre administrator and recognize the Chief Psychologist as a resource and support. A lack of direct clinical supervision, if that is in fact the case, would represent a concern in terms of accountability and professionalism.

The Psychology Department is dealing with a number of complex issues related to quality care for the population of injured workers and their families. The department also plays an important role in the training of psychologists and has clearly documented expectations of psychological interns in the Internship Manual. These relationships with educational institutions help to ensure the currency of staff and to foster an environment where professional development is ongoing. The cohesion of the department appears somewhat threatened by (perceived) job security, and a work environment that staff dislike and consider inappropriate in terms of the need to maintain client confidentiality.

Both the draft 1998 Rehabilitation and Compensation Services Business Plan and the 1997 Business Plan note that the department has identified the need for a comprehensive review of the policies, procedures and practices as they relate to psychological impairment, referral and treatment to alleviate inconsistencies, improve services and make practices more understandable for clients and stakeholders. A similar and perhaps overlapping concern was identified in the November 1993 discussion of Psychological Disabilities and Workplace Stress by the Chief Appeal Commissioner which identified the ambiguities in the governors' policies concerning the compensability of claims involving mental aspects of work.

2.4.4 Rehabilitation Centre

The Leslie R. Peterson Rehabilitation Centre is located in Richmond, BC. It provides direct rehabilitation services to clients of the BC Workers' Compensation Board. Injured workers can access multidisciplinary care at the Centre through a series of specialized programs: the Hand Program, the Head Injury Program, the Interdisciplinary Pain Program, the Work Conditioning Program, the Occupational Rehabilitation Program, the Worksite Reintegration Program, the Functional Evaluation Unit and the Medical Rehabilitation Program. The Centre's resources also include industrial workshops, a residence, and a health unit.

Until 1996, the Rehabilitation Centre was a separate department of the WCB, reporting directly to the President/CEO. In December of that year, it was incorporated with Medical Services and Psychology into the Rehabilitation Division.

The Rehabilitation Centre is widely considered to be a success, an opinion that the research findings support. This is reflected in its accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF). This internationally recognized designation was awarded in March 1995 for a period of three years for the Chronic Pain Management Programs, Outpatient Vocational and Employment Services, and Vocational Evaluation. CARF accreditation assures clients and stakeholders that the Rehabilitation Centre and its programs have been independently
surveyed and meet the high standards of practice and principles of quality service and sound administration that have been developed with the help of more than 40 organizations representing professionals, consumers and experts.

Another contributor to success is the Rehabilitation Centre’s internal Program Evaluation and Research Unit (PERU). The coverage, quality and timeliness of PERU’s reports ensure that findings are acted upon to improve operations.

The Rehabilitation Centre has a history of effective planning, first independently, and then as part of the Division. The CARF accreditation process has contributed to this planning ability. The Rehabilitation Centre has a clearly stated mission, the planning documents identify goals and objectives. Measurable outcome-focused targets are not always documented in the planning documents but may be found in program evaluation documentation. Planning for the Rehabilitation Centre is done in the context of reasonably extensive research so that the Centre appears to be cognizant of the challenges it faces when planning programs. There is evidence that the Rehabilitation Centre is participating in a variety of interdepartmental initiatives and that the plans are made in context of the organizational direction.

Structural changes in the Division are documented and some rationale for these changes is provided. Management staff report satisfaction with the structure. Evidence suggests that role clarification is an on-going issue at the Rehabilitation Centre. At this stage, we have not been able to determine if this is a symptom of staff anxieties during change processes, or if indeed, the roles are ambiguously defined.

The Rehabilitation Centre has appropriate policies in place regarding staff development, safety, recruitment, orientation, etc. The Centre has a history of encouraging staff to participate in skill and professional development. However, there is also a history of a sustained period of change, in organizational structure, in program structure, and in management. It would appear that changes at the Centre have caused considerable upheaval for staff. The evidence indicates that staff have been involved in this change process and that their commitment has made positive change possible.

It is not clear how PERU and the IS Department work together and how respective responsibilities are defined and shared. The available Operational Review is dated, but no documentation was uncovered that clarified the understanding of the roles of the two service parts of the organization. Since effective management of the information resource is critical to the effective management of the Centre, it is essential that lines of accountability and responsibility are clear for the information and systems development functions.

The development and maintenance of appropriate information systems seems to be an ongoing issue not only for the Rehabilitation Centre but for the Board generally. A legacy of cumbersome, independent central systems and competition for central IS services is the perfect environment to spawn quick-fix departmental systems. The Centre has experienced some of the problems related to this type of environment. PERU has stepped into the breach and provided some of the resources and expertise required.
Particularly significant is PERU's function in helping program staff to articulate measurable objectives and therefore identify key items for reporting. When the program evaluation grid has been developed for a particular program, it becomes possible to begin the systems and evaluation process development to meet the critical information needs.

PERU provides an enormous weight of evidence regarding programs achievement of their objectives. Due to time constraints, the researchers could review only a sampling of these reports. (In total, 60 reports were examined; they were selected to ensure maximum coverage by year, program and author.) In general, it would appear that the Centre's programs are achieving their objectives. A program in a specific quarter of a year might have failed to meet one or many of its objectives. However, since the researchers could not review every quarter for years for which data are available for each program, it would be inappropriate to make specific conclusions about each program. A similar qualifier applies to the conclusions regarding satisfaction and secondary impacts. Even with the wealth of evidence produced by PERU key indicators are not tracked for all programs and additional data development is required.

Although there is considerable variation by program and by stakeholder group, satisfaction with the programs offered by the Centre seems to be high. Through the PERU reports, secondary or unintentional impacts have been identified and recommendations made to correct these situations.

The Rehabilitation Centre is in a good position to maintain or improve results because of its program evaluation capacity. PERU has ensured the Centre's staff and management have results data to respond to maintaining and improving results.

The Centre has responded to research evidence, community consultations and other environmental trends to keep the programming relevant. Examples include the use of multidisciplinary teams to treat chronic pain clients, delivering rehabilitation services ‘closer to home’, using a time-based continuum of care and focussing on early return to work. The Centre consults with a variety of stakeholder groups in an effort to be responsive to consumer needs.

The Rehabilitation Centre and its staff are bound not only by the WCB Standards of Conduct but also, for the professional staff, by their own discipline's code of ethics or standards of conduct. In addition, CARF has some standards concerning the treatment of injured workers. No complaints of unfair or unethical conduct of the Centre or its staff by its clients or customers were presented to the researchers for review. There is an indication, however, that WCB funding might be viewed by the larger public as a source of inequity if WCB clients receive preferential service or access.
PART 2

REHABILITATION MATTERS: OPTIONS

Part 2 of this report examines where the WCB’s rehabilitation of injured workers fits within the broader context of rehabilitation in British Columbia and what options to the current model exist. It examines some of the larger societal questions regarding rehabilitation and the WCB’s responsibilities. It concludes with some options. Some of these relate to improving program delivery within the existing model, and some are alternatives to the status quo.

Most of the research conducted under this task is associated with being able to respond to future needs and challenges.

For the most part, the research relied on literature already in the public domain. A few interviews were conducted to confirm information or seek information on other systems in BC.

1. WHAT IS THE ENVIRONMENT IN WHICH REHABILITATION IS PROVIDED AND HOW IS IT LIKELY TO CHANGE IN THE FORESEEABLE FUTURE?

Over the last two decades, there have been major changes in the BC economy. The most important of these in terms of workers’ compensation include a shift from resource-based to service- and technology-based industries, an increase in self-employment and part-time work, and an increase in the role technology plays. As communications and awareness have improved among the general populace and as costs have increased, so has the demand for a greater role for workers and the public in setting the rules of work, for fairness, for cost control and for accountability.

Many workers’ compensation systems around the world have undertaken varying reform measures over the last two decades. Frequently, these reforms have placed a greater emphasis on prevention, and on rehabilitation as a way to reduce costs and foster early return to work. In this Section, we discuss some of the most important economic, social and technological factors and their implications for rehabilitation of injured workers in BC.

1.1 Economic Factors

1.1.1 Expanded boundaries: BC businesses operate not just within Canada or even within North America, but within the global economy. Increased international competition, particularly with countries that pay much lower wages, has led to shrinking profit margins for many industrial sectors. (WP451, p.9)

1.1.2 Regulatory change: The legislative and regulatory structure within which firms operate has changed, and in many ways become tighter as more areas are regulated. (WP451, p.9)
1.1.3 *Industry base:* There has been a shift from resource-based to knowledge and service industry employment; currently about 75% of B.C.’s total economic output is in the service sector and growing. (WP168, p.1) The largest single employers in BC in the mid 1990’s are retail trade (12.5%), general manufacturing (11.5%), and health & social services (9.3%). The most significant decline in 1995-96 was in the forestry sector, which witnessed a 30% drop in the sector total. (WP295, p.i)

1.1.4 *Business size:* The number of businesses in BC has grown by an average annual compound rate of 3.5% to a 1995 level of 151,000. Over 75% of all BC companies have less than 5 Average Labour Units (ALU’s). In total, these small companies account for less than 25% of total ALU’s. Very large firms in BC representing less than 1% of total companies, account for almost 40% of total ALU’s. If one-person self-employed businesses are included, the number of total businesses in BC doubles and the proportion of very small businesses increases from 75% to almost 88%. (WP295, p.ii)

Almost all job creation is taking place at the small business level.

1.1.5 *Employment vs self-employment:* Changes in the labour force include a growth in ‘non-standard’ employment especially in the self-employed/contractual category, which nationally accounted for all the net employment creation in the 1990’s. (Government of Canada statistics) In BC, the proportion of self-employed in the working population has grown at an average annual compound rate of 5.1% over the past 21 years, while the non-self-employed proportion has undergone an annual average growth of only 2.2%. In 1976, self-employment accounted for 12.5% of total employment. Estimates for 1997 indicate that self employment represents 20.6% of total employment. This translates to 1 out of every 8 employed persons in 1976, and 1 out of every 5 in 1997.

Comparing BC data for self employment to Canadian averages for 1987 to 1996, it is clear that BC has maintained a higher percentage of self employed persons than the national average. (WP295, p. i, 12, 14)

1.1.6 *Full-time vs part-time employment:* Part-time employment in BC currently accounts for 20% of the provincial total. This figure has not changed dramatically for the past 15 years, but it does represent a significant increase from the mid 1970’s when it accounted for only 15% of the total. (WP295, p.i)

1.1.7 *An aging workforce:* One of the most dramatic changes in the BC workforce is its aging. A changed demographic workforce profile emerges as the population ages. The 35-44 year old baby boomers currently comprise the largest employment age-group.

In 1976, 15-24 year olds made up almost 25% of the workforce; in 1996, this age group represented less than 15%. The 45 year and older proportion of the workforce has increased from 28.7% in 1976 to 31.2% in 1996. The contribution to total employment by those 55 and over has dropped slightly; however, increased representation by this age group can be expected in the future as baby boomers continue to move through the age groups. (WP295, p.17)
1.1.8 **Gender**: Women continue to enter the workforce, predominantly in the service sector, at a faster rate than men, and are now 45% of the workforce.

1.1.9 **Ethnicity**: The ethnic mix of the working population has changed and projections indicate that BC’s visible minority working population will grow from 14.5% in 1991 to 24.1% by 2016, or almost 1 in 4 workers. Statistics Canada reports that BC has the highest increase in immigrants among the provinces, up 25% from the last census, and at a rate twice the national average. With 7 out of 10 immigrants living in metropolitan Vancouver, Vancouver’s total immigrant population increased by a third between 1991 and 1996.

1.1.10 **Unemployment rates**: Unemployment rates are relatively high.

1.2 **Economic Factors: Implications for WCB Rehabilitation Services**

1.2.1 **Focus on costs**: Increased competition and regulation, together with shrinking profit margins, has forced industry and the WCB alike to focus on cost-cutting and will likely force organizations to focus increasingly on their effectiveness. Workers’ compensation legislation and the cost of providing benefits can have major impacts on the competitive advantage of employers. (WP216, p.23)

1.2.2 **Injury and illness type**: The change in industry base has resulted in a change in the type of injuries and illnesses occurring. (WP204, p.8) Most significantly, there has been a decrease in the traumatic-type of injuries for which the Workers’ Compensation Act was originally designed, and an increase in lower back problems, repetitive strain, chronic pain, stress and occupational diseases. The hazards of industrial and resource-extraction have been replaced by long hours of sitting in front of a video display terminal. As workplaces become safer, the direct cause and effect accidents or illnesses are being replaced by complex claims that involve difficult medical issues linked to occupational overuse. These claims involve issues of causation, diagnosis and the nature and extent of the worker’s disability. Disabling conditions without clear causation are increasing the costs of evaluating and settling cases. (WP451, p.9) The duration of disability has also increased.

‘Compensation for stress related physical and psychological disabilities has become a central topic in workers’ compensation. We heard the view expressed that the struggle to address this issue exposes the flaws of the present system, which focuses on the injuries and diseases arising directly out of and in the course of employment, and which did not contemplate impairments or disabilities which arise gradually and over time. This suggests that the workers' compensation system will have to undergo some reengineering to address the issues arising out of the evolving work environment and the concomitant tensions that are introduced into the work/family nexus.’ (WP266a, p.11)

‘There was a great deal of diversity among some of those we consulted on the "philosophy" of compensating stress related claims, just as there is diversity across
jurisdictions on current policy. The differences relate, at least in part, to whether mental-
mental stress (i.e., stress not related to an "accident") should be compensated at all, and
whether any or which non-work factors should be included in determining the extent to
which stress is attributable to the workplace.’ (WP266a, p.11)

1.2.3 Definitions: The changing nature of the workplace and the people in it are challenging the
traditional definitions of such words as ‘workplace’, ‘injury’, and ‘disease’. ‘Current
definitions are becoming increasingly anachronistic as the workplace evolves.’ (WP266a,
tab 1, p.6) For example, ‘telecommuting and other work at home initiatives blur the
delineation of the workplace.’ (WP266e, p.54)

1.2.4 Size of workplace and placement of injured workers: Larger firms are generally more
able to accommodate injured workers’ return to work through graduated return to work
(GRTW), light duties and modifications to jobs and/or work stations. Smaller businesses,
particularly very small businesses with five or fewer employees, do not have the
flexibility to make the necessary accommodations. This increases the challenge in
finding suitable locations for GRTW etc. As the WCB itself has noted, there is a need to
develop special strategies for small businesses.

1.2.5 Alternative work schedules: Flextime, compressed workweeks, job sharing, work at
home and part-time work all give employers less control of the work environment and
safety within it. This may impact on ‘safe’ and ‘durable’ returns to work.

1.2.6 Workplace attachment: The growth in self-employment and contractual employment
alters traditional patterns of workplace attachment and thus challenges the goal of
rehabilitation services. If workplace attachment does not exist pre-injury, how are
rehabilitated or retrained workers returned to pre-injury jobs? Traditionally, WCB
rehabilitation services have been tied to the state of employment. As non-standard work
arrangements increase, new strategies will be needed that uncouple WCB service
provisions from the job and attach them to the workers themselves.

1.2.7 Aging workforce: Age brings deteriorating health for most people. Older workers on
average take longer to heal after an injury or illness. This means longer treatment with
concomitantly longer periods out of the workforce. And the longer an injured worker is
absent from work, the less likelihood there is for a successful return to work.

The aging population will also influence the number of cases with non-compensable
conditions or disabilities superimposed on compensable conditions.

Over the next 20 years, as the baby boom group moves into the 45-54 and 55-64 age
groups, many issues such as health care, workers’ compensation and ergonomics will
require greater consideration by all stakeholders. (WP295, p.19)

‘It is estimated that by the year 2005, the population in British Columbia will have
increased by 1 million, most of which will be composed of people between the ages of 34
to 64’. (Kunin, 1993, cited in WP409, p.7)
1.2.8 Education levels: Workers in industrial settings often require far less education due to the physical nature of their jobs. ‘As jobs within the traditional sectors become scarce or require advanced knowledge of computer control systems, a disabled worker from a sawmill may find it impossible to return to a comparable job within the same workplace. Finding employment options in related industries or in a new sector may require intensive retraining and, for older workers in particular, may pose an insurmountable challenge.’ (WP451, p.10) ‘The value placed on intellect, advanced education and adaptability mean fewer employment prospects for people with the double disadvantages of impairments combined with limited education and skills. Further, individuals whose social and adaptive functioning is impaired by mental disorders are particularly disadvantaged in a highly competitive job market.’ (WP204, p.8)

Many older workers have less education than younger persons in society. It is also more difficult to learn as one grows older. Thus retraining may not be a suitable option for some older workers.

1.2.9 Gender: Women are entering non-traditional occupations in which a greater number of ‘non-standard’ injuries will likely occur, suggesting the need for a rehabilitation model to address these injuries. Moreover, there is some suggestion that the rehabilitation models developed for the predominantly male workforce may not be suitable for women.

1.2.10 Ethnicity: Different ethnic groups appear to have a different take up rate in the provision of services. The Rehabilitation Centre, for example, sees a greater number of first-generation Italians and Indians than it does Chinese. This could result from the type of work different ethnic groups are involved with, different approaches to injury within different cultures, or the use of different therapies to deal with injury and illness. The increase in immigration — coupled with changes in the resident population’s approach to traditional medicine and rehabilitation — could result in an increased demand for alternative therapies, utilization of excess capacity in the health system, and contracting out of services. This in turn raises questions of quality control and access.

Another issue resulting from the change in the ethnic make-up is the likely demand for services in languages other than English.

1.2.11 Grounds for compensation: If injured workers are unable to return to work for reasons related to lack of English (or French) language skills, general unemployment due to age or poor education, or other underlying conditions, should the WCB compensate or provide additional rehabilitation services? While the literature poses this question, it does not provide an answer.

1.2.12 Unemployment rates: WCB rehabilitation efforts will need to consider the structural job shortage for both abled and disabled workers. Higher unemployment rates affect marginalized workers, such as those with disabilities, to a greater extent. (WP451, p.11)
‘Findings from The WCB of Ontario studies (Johnson et al., 1993; 1994) indicate that unemployment rates disadvantage LB injured workers and influence disability duration. The effect of high unemployment (whether occupational or regional) may be particularly pernicious for LB occupationally injured workers. For example, RTW opportunities are substantially reduced during times of high unemployment simply due to the increased availability of other workers (Johnson et al., 1993; 1994). RTW is also determined by a number of other factors such as age, sex, education, and the number of RTW attempts (Johnson et al., 1990; 1993; 1994). Thus, while unemployment alone may decrease the likelihood of a successful RTW outcome, the combined effect of all these variables may serve to further decrease the likelihood RTW following a LB injury.’ (WP409, p.47)

1.3 **Social Factors**

1.3.1 *A larger public role:* There is an increase in the demand for public participation, in all walks of life, not just workers’ compensation. It is fueled by improved communications, better education overall, and more awareness.

1.3.2 **Accountability:** A concomitant of improved communications and awareness — and of economic constraints — is the demand for increased accountability. Again, this applies in all walks of life, not just workers’ compensation. A visible product of this demand is the accountability framework developed by the Auditor General and Deputy Ministers’ Council. Freedom of Information legislation allows the public to scrutinize the workings of public agencies. Employers and others are demanding greater cost consciousness and businesslike practices on the part of public sector management.

1.3.3 **Professionalism:** The public generally is demanding more professionalism among service providers. As people become more aware and knowledgeable, and as such media as the Internet make huge amounts of information immediately available at very low cost, this demand is likely to increase.

1.3.4 **Choice:** People generally want more choice. They want to decide for themselves who will provide services to them, and how and when those services will be provided. If they don’t like the provider, they want to be able to change to one of their choice.

1.3.5 **Access:** With the move towards self-employment and individuals holding down two or more part-time jobs, the traditional hours of business have changed. Through community practices, many can see a medical practitioner or dentist at a time that suits them, not the service provider. The demand for access during evenings and on weekends is likely to increase. The Ministry of Health has placed an increasing emphasis on provision of health services ‘closer to home’.

1.4 **Social Factors: Implications for WCB Rehabilitation Services**

1.4.1 **Larger stakeholder and public role:** Stakeholders, in particular employers and workers, but also others such as physicians, nurses, vocational rehabilitation providers, and the general public, may demand a larger role not only in informing policy and procedures,
but in the actual delivery of services. This has been recognized, for example, in the case management model. There may be a demand for more (or reinstatement of) advisory committees to ensure stakeholder input into the decision-making process.

1.4.2 Accountability: An increased role for stakeholders and the public should address some issues of accountability. However, there will likely be a continuing demand for better public reporting of accurate and well-defined statistics, and of effectiveness and cost-effectiveness measures. This should happen as a matter of course, if the Auditor General’s accountability framework is implemented.

Accountability issues include concerns over the rising costs of rehabilitation. This in turn engages the debate over fairness and equity. It also raises the issue of what the on-going costs are when return to work efforts fail.

1.4.3 Professionalism: There will likely be a demand for increased professionalization among service providers. Accreditation through such programs as the Vocational Rehabilitation Masters degree and disability management certification should meet this demand to some extent.

1.4.4 Choice: There will likely also be an increased demand for information about and choice in terms of treatment plans and services. Requests for medical alternatives to mainstream health practices, for example, may occur. In this regard, the Yukon WCB Act specifically now recognizes native healing methods.

1.4.5 Access: In terms of rehabilitation, access issues include hours of business, location of services, and language of service. Rehabilitation is provided to workers who are not working. Theoretically they should be able to attend during day time hours. However, with working spouses the norm, the availability of services in the evenings and on weekends may become an issue. The closer to home services are provided, the more accessible they are. This and the language of service have implications for the WCB in terms of having services provided by external contractors rather than staff.

1.5 Technological Factors

1.5.1 Increased use of technology: Technology, primarily in the form of computers, is being used more and more in every aspect of work and living.

1.5.2 Demand for data: Increased access to technology brings with it a demand for ever more information.

1.6 Technological Factors: Implications for WCB Rehabilitation Services

1.6.1 Availability of technology: The need to equip staff with up-to-date technology will remain, accompanied by the necessary training requirements. This has significant time and cost implications for the Board as capital investment is high and technology is constantly changing.
1.6.2 *Data*: There will likely be increasing demands for data on rehabilitation-related issues, disability levels and types, labour market statistics, and in particular outcomes such as returns to work and cost-effectiveness information. Trend forecasting may also become more important with respect to allocating scarce funds.

1.6.3 *Use of technology in the treatment of injury*: As technological advances are made, the array of diagnostic technology to manage treatment, particularly of ‘new’ occupational diseases will expand. Increased diagnostic ability will likely increase demand for its use. The questions this raises are how effective and useful are these machines relative to their costs, and when is enough is enough?

1.6.4 *Compatibility*: Increasingly communications is by electronic means. This requires a level of compatibility among workers, employers, health care personnel and rehabilitation providers in a variety of ways, and through a variety of access points.

1.6.5 *Injury arising from use of technology*: The widened use of cellular phones, pagers, portable computers, shared office, neighbourhood telebusiness centres etc. is resulting in an increase in stress claims and injuries such as carpel tunnel. There may also be unknown health effects from the technology itself. (WP266, tab 1, p.8)

1.7 *Medical Factors*

1.7.1 As noted in Point 1.2.2, the types of injuries and illnesses are changing over time. The 1993 Annual Report of the Rehabilitation Centre noted that ‘The shift in the B.C. economy from resource- to information-based industries has led to a decline in traumatic injuries and an increase in repetitive strain injuries (RSIs).’ (WP100, p. 17)

1.7.2 The number of stress claims has significantly increased in the last few years and is likely to continue doing so. (Submission H-UNI-095, p.1)

‘The subject of work stress and its effects is an area in which causality remains very unsettled. Stress at work exists to some degree or another in all employment. The interaction between stress at work and at home is not clearly understood. The distinction between so-called positive stress factors and negative stress factors has not been clearly drawn. Nevertheless, I am of the opinion that difficulties in sorting out causal relationships cannot bar the consideration of claims. There are many areas in which claims are routinely considered, despite such difficulties. For example, post-traumatic stress is a difficult area; the existence of a trauma represents only a minimal guarantee that the stress is employment-related and yet the Board considers post-traumatic stress claims compensable. Claims for cancer, especially where they are not associated with a process or industry listed in Schedule B, have posed vexing evidentiary problems but have been viewed as compensable. While conditions with controversial diagnoses may fall outside of the scope of the Act, recognized disease entities and injuries cannot be barred from consideration on the basis of evidentiary problems.’ (WP22, p.284)
1.7.3 ‘In the future, the list of medical conditions that could potentially be covered under the legislation will continue to grow and contemporary trends indicate that establishing causation will become even more problematic. For example, the increasing incidence of cancers in the general population, and ever expanding array of chemicals used in commerce and in the home, a growing number of home based workers, an aging workforce and the development of new technologies for use in the workplace will all add to the complexity of policy development and adjudication. Calls from some employers to restrict occupational disease compensation are likely to increase on the basis that it is too hard to determine work-relatedness. At the same time, there will be increased demands from other stakeholders to extend the scope of disease coverage on the grounds that, if a disease is work-related, it should be compensable.’ (WP154, p.12)

1.7.4 A briefing paper prepared for the commission in 1997, entitled Medical and Legal Issues Related to the Recognition of Occupational Disease, notes: ‘The occupational disease provisions have, at times, generated considerable controversy. Stakeholders have challenged the appropriateness of having separate legislative provisions for occupational disease; questioned the principle of scheduled coverage; alleged a lack of leadership by the Board in recognizing occupational diseases and a lack of diligence in keeping the schedule current. The following fundamental questions, identified in 1983, continue to be posed today:

- How should ‘occupational disease’ be defined?
- Should occupational diseases be treated legislatively in a different manner than personal injuries? (i.e., Should there be different requirements for compensability, different time limits for applying, different compensation provided?)
- Should the Board be required to adjudicate all occupational disease claims on a case by case basis under open-ended statutory provision or should there be schedules which establish presumptive causal connections between certain occupational diseases and certain industrial processes?
- If presumptive schedule are to be used, should Schedule B be expanded, and if so, what criteria should be used for inclusion or amendment?
- If schedule B is to be maintained, who should have responsibility for conducting reviews and deciding on changes?’ (WP154, p. 9-10)

1.7.5 Definitions and our understanding of pain are changing. For example, ‘Contemporary views of pain now recognize the interactionary nature of sensory, affective and cognitive features and so the Specificity Theory is no longer favoured by people in the field (Hill & Chapman 1989; Melzack & Wall, 1982). Recently Fordyce (1988) has proposed that pain be divided into dimensions of Nociception, Pain, Suffering, and Pain Behavior. However, for the purposes of this report the Gate Control Theory proposed by Melzack and Wall in 1965 will be adopted. This theory, which currently guides present research, adopts the view that pain is comprised of sensory-discriminative, motivational-affective, and cognitive-evaluative characteristics (Melzack & Wall, 1987). In other words, this model best reflects the biophysical characteristics of pain presentation seen at the Workers' Compensation Board.’ (WP103, p.4)
1.7.6 ‘The British Columbia Task Force on Chronic Pain Syndrome adopts a different approach to these issues, suggesting that while an organic cause can usually be identified for chronic pain, chronic pain syndrome is more complex, as biological, psychological and social/economic factors must all be considered. The Task Force identifies several risk factors, that is, things which can be corroborated with the occurrence of this condition.’ (WP123, p.2)

‘When health care providers fail to care appropriately for chronic pain patients, they inadvertently add to the difficulty and increase the patient's problems, primarily confusion, frustration, and hopelessness. Beck & Lustig (1990) cite common problems, including:

• Health care providers disbelieve that patients have pain in the absence of demonstrable pathology.
• They treat chronic pain from an acute pain model.
• They tend to under medicate patients and overestimate the seriousness of iatrogenic drug addiction.
• They use placebos incorrectly.
• They do not refer patients to psychological or psychiatric services until other treatment strategies fail (p. 732).’ (WP288, p.11)

1.7.7 A report prepared by staff in the Board’s Psychology Department states: ‘Controversies surrounding the etiology, treatment, and management of chronic pain continue despite the rapid expansion of research and the advancement of clinical practice in the area of pain-related occupational disability. There does not exist an agreed-upon, unifying model of diagnosis and rehabilitation of pain-related disability; rather, multiple often competing and conflicting models currently operate, both in the subject literature and practice. Clinical practice, health care, and compensation policies are particularly vulnerable to sociopolitical and economic pressures as theoretical and empirical support varies from model to model.’ (WP391, p.1)

1.7.8 Our understanding of the appropriate use of medications is changing. For example, ‘If opponent process theory is directly applicable to the clinical situation, then elimination of the use of opioid medication should be a high priority in the treatment of any chronic pain syndrome. Expressions of support for chronic prescription of opioid medication are in vogue ... However, arguments in favor of chronic prescription of opioids probably are not applicable to chronic nonmalignant pain conditions since there is empirical evidence from well-controlled animal studies that suggest that hyperalgesia may be promoted by chronic opioid use and there are case studies that suggest that elimination of analgesic medication may lead to improvement in chronic pain conditions.’ (WP408, p.14)

1.7.9 Different strategies for treatment are being considered. For example, ‘Over the next decade, increased emphasis will be aimed at prevention in each of three phases, primary, secondary, and tertiary. A primary prevention strategy is aimed at preventing symptoms
or disease from occurring. This approach thus requires ongoing education and active participation by both workers and employers (Frymoyer et al., 1991). Secondary prevention involves returning the individual to function following the occurrence of the injury (Frymoyer et al., 1991). Convincing empirical support for this approach has been demonstrated (Wiesel et al., 1984a; Lancourt et al., 1992). Tertiary prevention refers to the management of disabled individuals in order to maximize functional ability (Frymoyer et al., 1991). A success is reported, the natural history of low back disability and statistics on return to work are not promising (Froymoyer et al., 1991; Johnson, 1994a,b).’ (WP409, p.15)

1.7.10 There is a difference between risk factors for injury versus risk factors for chronic disability resulting from injury: ‘... much of the literature deals with predisposing or risk factors for the injury itself (i.e., risk factors for injury claims), and factors predictive of poor treatment outcome. Factors associated with the injury itself are therefore distinguished from factors associated with the disability before and following treatment intervention. However, it is apparent that there is substantial overlap between these sets of factors. For example, pre-injury risk factors such as physical fitness or smoking have been found to be of importance in modulating the individual's recovery from the injury.’ (WP409, p.15)

1.8 Medical Factors: Implications for WCB Rehabilitation Services

1.8.1 Increase in demand for recognition of a wider range of injuries and illnesses and for the provision of new treatments and medications poses both policy and cost issues for the WCB, namely to what extent are these demands to be met and at what cost?

‘Rising health care costs, heightened consumer awareness, advances in medical understanding, increased sensitivity to cost driver and the need for financial accountability all direct the Board to better articulate the reasons and basis for delivering services in a responsive, relevant and efficient manner.’ (WP403, p.1)

‘The costs associated with health care utilization have, in some countries, risen faster that the rate of inflation (Cats-Baril & Frymoyer, 1991). Compensation costs in British Columbia have increased dramatically, primarily due to rising health care costs (WCB, 1993a). Age is a very strong predicator of [lower back pain] and chronic disability, and will continue to be a major factor particularly in its impact upon the health care delivery system in the next decade (Frymoyer et al., 1991). More and more resources will be allocated to meet the needs of a progressively more aged population over the next few decades (Rybash, Roodin & Santrack, 1991). It is estimated that by the year 2005, the population in British Columbia will have increased by 1 million, most of which will be composed of people between the ages of 34 to 64 (Kunin, 1993).’ (WP409, p.7)

1.8.2 In a presentation to the commission, the Vice President, RCS Division noted: ‘Where possible we're looking for alliance with public sector facilities to reduce our queues. So we have talked to community health boards about making available to us surgical times
and facilities to enhance our ability to provide workers with the very best of service.’ (WP25, p.69)

1.8.3 A program evaluation report on the Functional Evaluation Unit, First Quarter 1997 noted:

‘The Future

1. Increased co-ordination across systems
2. Family physician role: supports employment link; comments on impairments, not disability (OMA/BCMA)
3. More clinical practice guidelines; less autonomy; evidence based treatment
4. Increased workplace disability management
5. More financial accountability (including fee schedule negotiations)
6. Role of preferred provider networks
7. Utilization management
8. Strong emphasis on measurement (program evaluation)
9. Case management more efficient by use of computer systems
10. Increased public debate.’ (WP116, p.38)

1.8.4 ‘Structural changes in the labour market affect the kinds of impairments the result in work disability. The value placed on intellect, advanced education and adaptability mean fewer employment prospects for people with the double disadvantages of impairments combined with limited education and skills. Further, individuals whose social and adaptive functioning is impaired by mental disorders are particularly disadvantaged in a highly competitive job market.’ (WP204, p.8)

2. WHAT IS THE KNOWN AND DEMONSTRATED EFFECTIVENESS OF REHABILITATION?

VOCATIONAL REHABILITATION

2.1 Most of the literature reviewed suggests that ‘vocational rehabilitation mitigates the disabling consequences of workplace injuries with respect to returning the injured worker to employment’. (WP38, p.178-179) Vocational rehabilitation forms a major part of the work of most workers’ compensation systems around the world. In Canada, the CPP recently conducted a pilot study and based on the results established a full-fledged vocational rehabilitation program for CPP Disability beneficiaries. The study supported the establishment of a permanent rehabilitation function as part of the CPPD on the grounds that: ‘(i) significant cost-savings are possible ... (ii) rehabilitation is an effective caseload management mechanism used by most other providers of disability insurance; (iii) several lines of evidence suggest that providing rehabilitation services could significantly increase the proportion of CPPD beneficiaries who successfully return to the workforce ...’ (WP298, p.ii)
2.2 However, as Berkowitz noted, rehabilitation can be expensive and it is by no means certain that the costs can be justified by the results. (WP275) Not all stakeholders in all jurisdictions appear convinced of the effectiveness of vocational rehabilitation in returning injured workers to work, or at least of providing vocational rehabilitation services without some form of targeting. For example, Oregon in 1987 and 1990 restricted the use of vocational rehabilitation.

2.3 As important as vocational rehabilitation is to injured workers, employers and the Workers’ compensation system, measurement of their effectiveness is elusive and controversial. (WP266e p.46)

2.4 Demonstrating effectiveness is not a simple matter. There is both a lack of comparable research, particularly of the long-term impacts and a lack of agreement on common definitions within existing research. The enormous variability in terms of eligibility, delivery etc (as discussed in Issues 3 and 4 below) make comparison very difficult. These problems are compounded by the issue of attribution, i.e. determining what is due to the vocational rehabilitation services, and what is due to other factors. There are also several disincentives within the various systems that work against the positive outcomes of vocational rehabilitation.

2.5 Return to work is not a simple matter. It has many facets including:
- amount of time worked (full-time/part-time; graduated return to work etc.);
- level of income (higher, same or lower than salary at the time of injury); and
- whether return to work is sustained.

2.6 Terminology and definitions may differ from study to study, and may not be stated in the research. For example, how should a ‘successful’ rehabilitation intervention defined? Is it determined by the degree of medical recovery, the success of a return to work, the extent to which the worker was able to attain the lifetime earnings profile he/she could have expected had the injury not occurred, or is it measured by the cost-effectiveness of the intervention, a concept which itself is difficult to define? (WP266e tab 2 p.46)

‘In general, researchers have not attempted to address this critical issue. Instead, they have chosen their own measure of success and tried to evaluate the influence of vocational and medical rehabilitation interventions on achieving the successful outcome. Economists have tended to measure success by the return to employment and the size of post-injury earnings. Medical researchers have concentrated on physiological measures, while sociologists have considered effects on personal and family lives.’ (WP266e tab 2 p.26)

2.7 Recent research suggests that a one-time measure of return to work either at the end of services or shortly thereafter is not an accurate assessment of return to work. Such an approach treats the first return to work ‘as a permanent stable outcome’ and biases long-term results. (WP124)
2.8 There is relatively little hard data, particularly consistently defined data collected over a sufficiently long period, to allow the necessary research and analysis to arrive at a firm conclusion on the effectiveness of rehabilitation. (WP38, p.159) In some areas such as the impact of vocational rehabilitation on the labour market, there has been very little research at all.

A 1998 study on US Social Security Disability Insurance, which faces an enormous problem since not more than 1 in 500 disability insurance beneficiaries leaves the rolls by returning to work, reported that ‘relatively little is known about the confluence of factors that helps beneficiaries overcome employment challenges and disincentives and the factors that inhibit them from achieving an earnings level that leads to self-sufficiency. (WP341, p1)

2.9 Even where return to work has been studied and demonstrated, attribution is not always clear. The 1994 WCB Evaluation, for example, found that only 43% of the workers who returned to work ‘credited the WCB of BC’s vocational rehabilitation services with helping them to find or keep the job they returned to’. (WP20, p.70) There was a similar finding in the CPPD evaluation: ‘Clients’ self-reported assessments of the effectiveness of rehabilitation interventions are generally low’ (WP298, p.65) although as the evaluators suggested: ‘Other data show that a majority of beneficiaries whose benefits were ceased as a result of their participation in the NVRP found employment. This, in itself, would tend to indicate that vocational rehabilitation was useful in returning people to work, considering the very low level of CPPD beneficiaries who return to work without assistance.’ (WP298, p.viii)

2.10 Vocational rehabilitation never occurs in isolation. There are always other factors to be considered. These include changes in health status, changes in family situations, changes in the job market, the availability of jobs and whether, for example, there is a disability management program at the workplace. It is difficult for recipients of services to identify the cause/effect relationship. As the 1998 US Social Security Disability Insurance report found in its survey of DI beneficiaries who had achieved a range of work outcomes, ‘Respondents identified many factors that they believe affected their ability to return to work: services that improved health and functioning were paramount.’ (WP341, p.1)

2.11 Nevertheless, the research has identified some factors that affect return to work; these are addressed individually below. It is clear from the analysis that these factors do not act independently of each, but in various combinations, which complicates the research.

2.12 The type of rehabilitation: The jury is still out on which vocational rehabilitation services are the most effective for which clients. For example, some research suggests that GRTW are not likely to succeed, whereas other research indicates that these have a high success rate. Key variables related to success appear to be the extent to which the employer is involved with the injured worker from the time of injury; the size of the firm and its ability to accommodate injured workers in light duties; and the follow-up provided by vocational rehabilitation staff.
2.13 *The duration of rehabilitation services.* One issue raised by VRC’s in our interview with them was ‘How much is enough?’ The Liberty study made the same comment: ‘Among the most difficult issues that must be addressed by workers’ compensation boards is the determination of when the cost of a vocational rehabilitation intervention is not worth the potential benefit in terms of improved health or better job prospects for the worker. This problem is particularly difficult to address when, as mentioned before, there is no single accepted measure of what constitutes a successful intervention.’ (WP266e, tab 2 p.49)

The literature reviewed does not answer the question of adequacy. Butler et al. noted that those with higher education levels took a longer rehabilitation period but were more likely to sustain a return to work. And workers with higher replacement rates were less likely to experience multiple absences from work, perhaps because longer initial absences resulted in more complete recoveries. (WP124)

2.14 *The method of service delivery:* Vocational rehabilitation services can be delivered internally, by external providers, or by some combination. Gardner (1986) found that workers who received privately provided vocational rehabilitation were more likely to return to work than those who received publicly provided services. (Cited in WP38, p.161)

2.15 *The timing of Vocational rehabilitation interventions in relation to the date of injury:* It is well established that workers who are disabled and away from work have a 50% chance of returning after a 6 months’ absence; a 20% chance after a one-year absence, and only a 10% chance after two years’ absence. As the NIDMAR report ‘Strategies for Success’ states, ‘For a disabled worker, the chances of finding a new job after a long-term absence are often grim. Early intervention and graduated or transitional work options are made possible by disability management programs, maintaining the connection to the workplace and facilitating successful return to work.’ (WP448, p.2)

2.16 *Eligibility criteria:* How candidates are selected to participate in Vocational rehabilitation may affect outcomes. For example, research demonstrates that the more highly motivated an individual, the more likely that person is to return to work. The Oregon experience demonstrated that, in that state at least, mandatory vocational rehabilitation was less cost-effective than provision of services on a more restricted, targeted basis. As Berkowitz noted, selecting candidates for rehabilitation/return to work services is a delicate matter of how to achieve balance between equity and efficiency. (WP 275)

2.17 *The worker’s characteristics:* The worker’s age, gender and education level can all affect the likelihood of a return to work, as can membership in a labour union, and the type of injury sustained.

In an Ontario study of workers with permanent impairments, the researchers found that approximately one-sixth of the workers did not return to work. These workers were, on average, older and less likely to be union members. Their most distinctive characteristic,
however, was their low educational attainment: nearly 80% of them had less than a high school education. (WP124)

Those in the study who did return to work were more likely to be younger, be high school or college graduates, and be union members. (Other research in the US suggests that union members are less likely to return to work (cited in Butler et al, 1983, 1983, 1990)). A separate study by Burkhauser and Daly (1995) and cited in Butler found that high school graduates are slightly more likely to be accommodated than non-graduates.

The reasons posited for these findings include the following:

- Aging reduces the capacity to recover from an injury and increases workers’ access to retirement benefits (Fenn, 1981, Butler etc. 1985, 1991).
- Workers with higher education often have less physically demanding jobs. They also generally have more control over the way in which they perform their jobs, allowing them to compensate for physical limitations by changing the manner in which they work. Employers are more likely to want to keep or accommodate better educated workers because they have greater investments in them, and the cost of replacing them is higher.

Unions do best at protecting workers’ time-of-injury jobs but contribute less to successful outcomes among those who return to work.

Persons employed in the public sector were, as expected, more likely to retain their jobs when injured than were private sector workers. (WP124)

In this cohort, gender did not significantly affect the probability of returning to work; however, other research in the US has found the opposite.

The nature of the injury also affected the outcomes to some extent. For example, workers with back conditions who returned to work were more likely to experience multiple absences than workers with non-back injuries. These results are consistent with the chronic degenerative nature of the physiological process that results in low back pain. Degenerative conditions worsen over time, leading to an increasing frequency of acute episodes and often to increasing levels of persistent pain. However, outcomes were not solely determined by the direct effects of injuries. (WP124)

Other personal characteristics identified by Berkowitz include the influences of culture, work ethics, and religious orientations. (WP275)

2.18 The worker’s relationship with his/her workplace at time of injury: Workers’ whose relationship with the workplace at time of injury were good are more likely to return to that workplace.

2.19 The willingness of the employer to accommodate: The Butler study found that employers are most willing to accommodate workers who are unlikely to leave the firm’s employ.
Employer accommodations that significantly affected post-injury patterns of employment were reduced hours, modified equipment and light work loads. These accommodations seem to have elicited very strong employee attachment effects. Workers receiving these accommodations were significantly less likely to experience multiple absences. (WP124)

The NIDMAR report ‘Strategies for Success’ also comments on the importance of both workers and employers being willing to cooperate in the rehabilitation process and the employer staying involved with the injured worker throughout the recovery process. The report cites several examples where the presence of a disability management program and trained staff to administer the program have reduced the time off work in major corporations and firms such as BC Hydro, MacMillan Bloedel, and Weyerhaeuser.

2.20 **Prevailing conditions in the labour market:** No matter how good the vocational rehabilitation services are, if there are no jobs to go to, injured workers cannot return to work. As labour markets tighten, jobs become scarcer, the types of jobs change (as discussed in Issue 1), and finding work for persons with disabilities becomes harder. Those who are older, with more physical disabilities, less education and perhaps language difficulties are less likely to be able to find jobs.

2.21 **Incentives and disincentives:** A wide variety of factors such as benefit levels, tax situations and program design itself can serve as incentives or disincentives.

In the US, the Policy Panel of Social Insurance ‘was charged with determining whether the design of the programs strongly encouraged Americans with disabilities to emphasize their impairments as a means to securing and maintaining disability benefits’. (WP204, p.1)

The Liberty study noted that ‘According to some research, there is apparent consensus that workers’ compensation benefits representing 90% of net income are, by and large, a disincentive to an injured employee to return to work. Generally in Canada, indemnity at this level of net earnings produces more than 100% of take home pay for disabilities of less than six months because of Canada’s marginal tax system.’ (WP 266a. tab 1, p.9)

The report notes that a number of studies have measured the net effect of benefit increases on claims activity. With few exceptions, this research has been conducted using data from the US. The findings of these can be generalized as follows:

- The probability that workers will become permanently disabled increases as benefit levels increase.
- Higher benefit levels result in longer durations of absence from work following both permanent and temporarily disabling injuries.
- Some studies have shown that the probability of returning to work is enhanced by the wage which the worker will be able to earn following a permanently disabling injury.
It appears that an increase in benefit levels is associated with higher accident frequency, longer absences from work and a reduction in the probability of return to work following the injury. (WP266a, tab 1, p.9)

However, some of these studies have also shown that the probability of returning to work is positively related to the wage the worker is likely to be able to earn following a permanently disabling injury. This suggests vocational rehabilitation programs aimed at increasing the worker’s post-injury earning potential will have a positive impact on the return to work. (WP266e tab 2, p.39)

An increase in benefit levels is strongly associated with higher accident frequency, longer absences from work and a reduction in the probability of return to work following the injury. These observations are presumably largely due to increased claims reporting and the reduced cost of work absence as a result of more generous benefits. This is not to say benefit levels are too high: ‘benefit levels which are set too low result in legitimately injured workers not reporting claims or returning to work too early, thereby increasing the probability of further, potentially more serious injury to the worker or to co-workers.’

The challenge is to find the best balance, i.e. benefit levels that ensure workers’ income is protected while providing incentives to return to work where possible.

Butler et al. note that in their cohort, ‘although benefit payments are a significant disincentive to work, they do not affect the stability of post-injury employment.’ (WP124)

2.22 Obligations regarding duty to accommodate: Some jurisdictions have provided incentives for employers to accommodate injured workers. These are discussed in further detail in Issue 4 and include such things as premium holidays. Some jurisdictions have introduced a legislated duty to accommodate. These obligations have varying impacts on return to work outcomes.

2.23 Return to work may be affected by one of several barriers that exist, regardless of the quality, timeliness, and extent of the vocational rehabilitation services provided. These barriers, which emerge through the recovery process, have been categorized in the Liberty study as follows:

Employer or workplace factors:
- pre-injury job availability;
- modified work availability — length of time accommodation required;
- concern over re-injury, safety;
- co-workers’ perception of injured workers;
- lack of co-ordination with WCB and worker for return to work;
- concerns regarding productivity of injured worker;
- previous job performance issues — worker may not be wanted back; and
- previous injury history for the employee.
Employee factors:
• expectation of 100% pre-injury health prior to return;
• lack of understanding medical aspects of pain vs harm;
• psychological barriers;
• concern over re-injury, safety;
• lack of co-ordination with WCB and employer for return to work;
• remuneration and hours of work issues;
• high benefit levels for injured workers;
• unionized environment; and
• worker may not want to return to employer.

Internal WCB factors:
• unskilled case managers;
• high turn over of case managers;
• regional structure of boards means a company may have several case managers to deal with;
• management of worker files rather than management of worker’s case;
• long response time to inquiries by workers and employers;
• lack of coordination with employer and employee for return to work;
• too many complicated appeals processes; and
• lengthy appeal processes — timely resolution virtually impossible.

It is clear that various combinations of these factors can have a significant impact on increasing the duration of off-work absence. (WP266a, tab 2 p.24-25)

2.24 Berkowitz posed some questions to participants at a USA/ILO International Symposium on Returning Injured Workers to Work in Turin, Italy, in 1989. (WP275) While there is some repetition with the above, these questions present yet another way of examining the issues regarding the effectiveness of vocational rehabilitation and serve to summarize the complexity in determining that effectiveness. They include:

• What methods exist for evaluating suitability for rehabilitation, for setting up plans for rehabilitation and return to work?
• What are the legal and administrative responsibilities of the employer in taking the injured worker back to a former job? What methods are provided for enforcement and penalties for non-compliance?
• Are there obligations on the worker to cooperate? What methods are provided for enforcement and for non-compliance?
• Whose responsibility is it to evaluate the suitability of a job to be offered to an injured worker? What are the respective roles and responsibilities of medical professionals and of WCB staff?
With respect to incentives and disincentives, Berkowitz noted that in so many ways the incentive-disincentive structure for employers is the mirror image of that which exists for workers.

His questions relating to worker incentives/disincentives include:

- How do the level of benefits relate to wage levels?
- Are there qualifying conditions? Are they stringent or flexible?
- Is there a waiting period during which no benefits are paid?
- If yes, are benefits paid ‘retroactively’ if the worker is out of work for longer than the waiting period?
- What is the relationship between the benefit and the worker’s pre-injury wage? (It would be expected that worker behaviour would be different when the benefit equals 100% of wages than if it were less than 100%.)
- What is the after-tax situation i.e. are benefits taxable and if so are they taxed at the same or a different rate than wages?
- What is the relationship between the worker’s wage and the total benefits received, where stacking is allowed; how do these compare after-tax?
- Is the worker eligible for permanent benefit for partial or total disability? If so, is the rate different from temporary disability benefits?
- How was the worker’s case handled initially — perhaps even during the first week of injury?
- Are permanent benefits tested on the ability to perform any ‘suitable’ job, not only the worker’s pre-injury job?
- Does the worker see the new job offered as socially unsuitable or not utilizing previous training, education, experience?
- What is the basis on which benefits are assessed
  - physical impairment
  - loss of wage-earning capacity
  - loss of wages?
- Is the system one that encourages the worker (through incentives) to insist on or exaggerate the extent of impairment in order to qualify for the maximum permanent benefit? If yes, the worker’s motivation to return to work may seriously be put into question, after insisting for some time on being unable to work.
- Will return to work reduce the level of benefits? If yes, it may act as a deterrent to motivation to return to work.
- Will leaving the benefit rolls result in other financial losses e.g. loss of medical benefits? If yes, the incentive to return to work will be that much weaker.
- What happens if an attempt to return to work proves unsuccessful? Does the system allow for easy return to the benefit rolls? Are there provisions for a work-trial period?
• Does the system provide mechanisms for an easy transition to the workplace e.g. less than full duties or less than full time without seriously suffering loss of status or without imperiling eventual placement at a regular job?

His questions relating to employer incentives/disincentives include:

• Does the method of assessment cause any discernible differences in employer behaviour?
• Do changes (increases) in assessment rate stimulate employer interest in claims administration?
• Does the employer have the possibility of saving money if he demonstrates co-operativeness and willingness e.g. to alter jobsites to suit the worker’s residual vocational capacities?
• Does the law permit subsidizing an employer in certain situations e.g.
  • to provide wage subsidies for a limited period of time to induce the employer to take a disabled worker back
  • to cover the costs of remodelling or adapting the worksite to eliminate architectural barriers?
• Are such provisions effective? Do employers appear to be eager to take advantage of them?

Finally, he asks whether the programs themselves are a part of the return to work problem. For example:

• Are workers driven to exaggerate the extent of their injuries, while employers may use a work injury as an opportunity to eliminate a disabled worker — or someone who prior to the injury was a nuisance, problem worker, or low producer — from the workforce?
• Do the programs work so that they keep people away from rather than encouraging them to return to the jobs they held before injury?

MEDICAL REHABILITATION

2.25 ‘The natural history of low back disability an statistics on return to work are not promising.’ (WP409, p.15)

2.26 A University of Texas report notes:
‘Somewhere between 20-35% of workers' compensation patients treated for spinal disorders might benefit from some type of reactivation (secondary care) treatment in the late acute, post-acute, or immediate post-operative phases of treatment. A smaller percentage of noncompensation patients need such care. Tertiary care is probably appropriate for 5-8% of patients becoming chronically disabled or not responding to previous surgical and nonoperative care. The higher cost of tertiary care should be justified by the ability of tertiary rehabilitation to help primary and secondary non responders to return to work, provide closure of nonmedical disability issues, and prevent
a lifetime of dependence on public entitlements. As the duration of disability increases, the cost of management and of benefits obtained from this successful treatment increase proportionately. This implies that documentation of outcomes becomes progressively more important as the cost of treatment and its intended socioeconomic benefit increase. Secondary care relies on the skills of a qualified allied health practitioner (usually a physical or occupational therapist) providing cost-effective care by use of limited space and equipment and with mainly consultative medical, psychologic, vocational, physical, and occupational therapy services in tertiary treatment facilitates the highest skill level for all professionals involved.’ (WP211, p.2065)

2.27 In a presentation the then Director of the Rehabilitation Centre noted that the most extensive and systematic study of the question how effective are physical activation work conditioning programs was completed by Mitchell and Carmen (1990).

‘They compared 703 Ontario compensation recipients, who received physiotherapy work conditioning program, to a comparable 703 who received regular treatment. Looking at the data up to the end of 1988, the entire work conditioning sample had a total days lost from work of 88,400. The comparison regular treatment group had a total days lost from work of 127,600.’ (WP157, p.5)

2.28 ‘The review of the literature, the overseas experience and the consultations within Australia all point to a range of best practice principles in return to work. These include:

- occupational rehabilitation and return to work should be workplace based;
- early intervention is a major requirement for those clients who need rehabilitation;
- not all clients will benefit from, nor need rehabilitation;
- corporate commitment from the top is required for return to work strategies to be implemented effectively;
- the organisational culture, directly or implicitly affirms human resource management principles where early return to work is seen as a guiding corporate principle;
- the organization should become the driver for integrating the key stakeholders in the managed care and rehabilitation of the injured worker;
- accidents and injury need to be responded to regardless of cause; the issue of liability, and claims management, is a separate but related feature of a workers’ compensation system;
- feedback loops, including computerised information systems, should be provided to guide action at the employer and the individual level; and
- consultative and tripartite arrangements are vital to having integrated management of the operating systems.’

Barriers to implementing a return to work model consistent with these best practices identified included: the capacity of employers to effectively manage the return to work of their injured workers, limited understanding of treatment costs and protocols, differing stakeholder agendas, and ‘the assumptions underlying re-employment, i.e that all workers
will be able to return to their pre-injury duties or that employers have a degree of flexibility in placing workers, is not consistent with experience.'

The characteristics of successful return to work endeavours are early intervention, workplace-focused activities, an open and communicative corporate culture and strong managerial commitment to safety and rehabilitation. The highlights of a holistic corporate approach to employee welfare including disability management might emphasize wellness programs, or work retention services but these disability management programs are typically designed to apply regardless of whether the disability is work related. (WP342, p.10)

2.29 ‘The Industry Commission Report on workers’ compensation in Australia (1994) indicated that rehabilitation has generally proven to be cost-effective although returns compared to outlays varied widely and that a range of performance indicators is required to measure the effectiveness of rehabilitation, and allow meaningful bench marking to occur. In a similar vein Kenny (1994) found in an Australian study of 3041 workers that those who had received rehabilitation had on average 3.33 weeks less time lost than all other workers, controlling for the nature of the injury.’

PSYCHOLOGICAL REHABILITATION

2.30 ‘Adolf Meyer (1866-1950) originally developed the concept of “multicausality” in psychiatry but recognized that psychosocial factors influenced the course and outcome of every illness, and that each patient must be seen and assessed as a person. Such a holistic view of medicine has been a hallmark inspiration, and source of pre-eminence of American psychiatry and it has rightly been claimed that an understanding of the psychosocial aspects of illness is one of the most important contributions that the behavioral sciences can make to medicine. Because mental illness has never comfortably fit the disease model, psychiatrists have raised fundamental questions about the medical model and proposed an alternative biopsychosocial model which includes physical, psychologic, and social elements. This is very much a model of human illness rather than disease and may apply equally well to non-psychiatric illness.’ (WP213, p.637)

2.31 Worker’s compensation boards in most jurisdictions are being asked to adjudicate a growing number of claims for work-related psychological disorders such as stress. The Association of Workers’ Compensation Boards of Canada has provided a concise statement on the current compensation policies for psychological disorders.

Psychological disorders can be classified into three broad categories:

- physical-mental: whereby the nature or treatment of a compensable physical injury has led to psychological problems;
- mental-physical: situations in which a stressful work environment has led to physical symptoms, such as a heart attack; and
- mental-mental: situations in which a patient alleges that he/she has developed a mental condition as a result of a psychologically debilitating work environment.
2.32 ‘Models of Diagnosis and Rehabilitation in Pain Related Occupational Disability’ (WP396) identified five models that were derived from the literature: biomedical, psychiatric, forensic, labour relations/systemic and biopsychosocial. The research found that the biomedical model was found to be primarily applicable with adaptable individuals in early/acute states of injury. The psychiatric model applied well to individuals who had histories of diagnosable mental disorders. The forensic model was most useful with individuals who had significant pre-existing or concurrent psychological and medical conditions as well as with those cases where major personal credibility issues were evident. The labour relations model applied well to individuals with attachment to the workplace who had relatively uncomplicated clinical profiles; it was particularly useful in the development of injury prevention programs. The biopsychosocial model was most applicable to individuals with a wide range of chronic pain conditions who were motivated to participate in multidisciplinary assessment and treatment with educational and psychosocial foci.

The paper concluded that ‘The applicability of a given model of diagnosis and rehabilitation in pain-related occupational disability depends largely on the time since injury and on the clinical complexity determined by pain presentation, co-morbid conditions, and pre-existing factors. Where the biomedical model is largely applicable to individuals with uncomplicated psychological profiles in early stages post injury, the systemic and biopsychosocial models become models of choice in later stages of injury and in cases where there exist complicating psychosocial and other clinical factors.’ (WP396, p.1)

The implications for compensation for each of these models have been identified as:

**Biomedical Model**
- Compensation for impairments with clearly identified organic causes only.
- Lack of specific built-in financial incentives for coping and well behavior.

**Psychiatric Model**
- Compensation for all diagnosable mental disorders arising from the injury: e.g., somatoform/pain disorders.
- Reinforcement for disability.

**Forensic Model**
- Compensation for the ‘honest’ client only.
- Appears an attractive option due to simplicity.
- Long term costs due to:
  - chronicity in incorrectly identified patients; and
multiple systemic safeguards necessary to detect malingering may cause service inefficiencies.

**Labour Relations/Systemic Model**

- Anticipated reduction in disability costs, long-term.
- Costs partly shifted to the specific accident employer.

**Biopsychosocial Model**

- Clear guidelines required for compensability if exact etiology unknown or interactive.
- Higher rehabilitation, lower compensation costs.
- Compensability primarily for treatment failures, and permanent damage.
- Compensation used as an incentive for rehabilitation to work. (WP403, p.2-6)

2.33 Many cases referred for psychiatric services involve chronic pain, much of it resulting from back or spinal problems. An example of the complexity of pain follows:

‘The patient who continues to experience pain and disability in spite of repeated investigations will often enter a stage of emotionality. A sense of helplessness results in depression. Family and marital problems are extremely common. Alcohol and prescription drug dependency are frequent compounding problems. Vegetative symptoms such as weight change, sleep disturbance, and cognitive changes are common. In fact, sleep disturbances are identified in 75% of our patients. The patient may also become angry. This anger may be focused on identifiable targets such as the physician, family, employer, or agency such as the WCB. It is often an expression of the patient's frustration with searching and continued pain. Many physicians make the mistake of becoming incorporated into their patient's fights with the insurance companies and compensation boards. Often this is a defense mechanism against the patient's anger. The physician realizes that the patient may begin to direct anger at a closer target — the physician. Unfortunately, a legal advocacy role may compromise what is medically best for the patient.’ (WP413, p.1970)

2.34 The research indicates that there is no agreement among practitioners:

- ‘The general concept that a person who is deconditioned from a spinal disorder will benefit from recovery of lost strength by weak muscles and lost motion by stiff joints makes intuitive good sense. Equally apparent, relief from depression, restoration of hope, and control of anxiety contribute to psychologic rehabilitation, and the abilities to work, enjoy recreation, and function in family and society determine social rehabilitation. Good sense and ample documentation tell us that the physical, psychologic, and social aspects of recovery are interdependent and that failure to attend to problems in one sphere can doom efforts to treat difficulties in the others. ... The general rationale of spine
rehabilitation is that assessment of the various aspects of physical, psychologic, and social deconditioning can lead to management that meets the needs of the individual and that such management can assist recovery.’ (WP211, p.2062)

• ‘Controversies surrounding the etiology, treatment, and management of chronic pain continue despite the rapid expansion of research and the advancement of clinical practice in the area of pain-related occupational disability. There does not exist an agreed-upon, unifying model of diagnosis and rehabilitation of pain-related disability; rather, multiple often competing and conflicting models currently operate, both in the subject literature and practice. Clinical practice, health care, and compensation policies are particularly vulnerable to sociopolitical and economic pressures as theoretical and empirical support varies from model to model.’ (WP391, p.1)

• ‘Assessing pain is complex. Many psychological tools help identify potential treatments, but unfortunately, uninformed or poorly-motivated practitioners have misappropriated some pain tests. The FCE industry collectively seems to have particular difficulty interpreting pain psychological tests appropriately.’ (WP288, p.17)

2.35 ‘Traditional medical approaches to chronic pain problems have been ineffective, with long-term success rates below 30%. Although there is no question that physical factors contribute to symptoms, it is evident that a range of psychosocial factors may occur secondary to an injury or disease.’ (WP211, p.2060)

2.36 With respect to stress, Comcare in Australia has reported that ‘By and large “stress management” courses are late-response palliatives which do not address the full range of organizational, personal and extra-organizational variables. The complex array of psycho-social worker characteristic interacting with the workplace environment implies that as far as the management of stress claims is concerned, the early diagnosis role must be carried out or at least supported by a professional of consummate skills (occupational physician, clinical physician, industrial social worker). This may be a professional of some ten to fifteen years standing. ... Even small systems delays can become intolerable (and expensive) for staff with particular stress conditions. For example, with post-trauma stress cases the treatment response should ideally occur within 72 hours. If the operation of the Stress Claims Management Centre model adds to processing and treatment delays (as is the common agency perception) then paradoxically it is adding to the ultimate cost of recovery.’ (WP342, p.39)
3. WHICH AGENCIES IN BC ARE FUNDING AND/OR DELIVERING REHABILITATION AND HOW DOES THE REHABILITATION PROVIDED BY THE WCB COMPARE WITH THAT PROVIDED BY OTHER AGENCIES?

VOCA TIONAL REHABILITATION

3.1 A wide variety of agencies in BC are involved in providing rehabilitation services. Those that have a funding and/or policy making role include:

- the federal government: Canada Pension Plan (CPP)  
  Employment Insurance (EI)
- provincial government: Vocational Rehabilitation Services (VRS) Ministry of Advanced Education, Training and Technology (MAETT) (previously MoEST)  
  Ministry of Human Resources (MHR)  
  Workers’ Compensation Board  
  Insurance Corporation of BC (ICBC)
- hospitals: e.g. BC Rehab  
  GF Strong
- private insurers
- employee organizations: e.g. BC Teachers Federation (BCTF)

Within some of these organizations there are specialized programs such as Community Support for Independent Living (CSIL) in the Ministry of Health, which provides funding for attendant care.

3.2 These agencies have adopted various ways of managing and delivering their services.

Case management, for example, may be fully internal, fully external or ‘dual’ with internal staff dealing with overall issues on a case, and external consultants handling lower level issues. Similarly, service delivery may be fully internal, fully external, or provided through a mix of internal staff and external providers.

Exhibit 5 shows the different ways in which some of these funders (Canada Pension Plan, Employment Insurance, Ministry of Education, Skills and Training, (now MAETT) the WCB, Insurance Corporation of BC, and a private insurer) provided case management and services as of 1997. The options within a specific organization show the different combinations of case management and service delivery actually used by that agency.
Exhibit 5
Case Management and Service Delivery Arrangements

<table>
<thead>
<tr>
<th>Organization</th>
<th>CM - internal</th>
<th>CM - external</th>
<th>SD - internal</th>
<th>SD - external</th>
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<tr>
<td>CPP</td>
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<td>EI (placement etc.)</td>
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</tbody>
</table>

Notes: CM = Case Management
       SD = Service Delivery
       op = option

3.3 In addition to the funders (who may also provide services), there are several organizations that are involved with delivering vocational rehabilitation services. Some of these agencies such as I AM CARES are generalists (pan disabilities). Others focus on a particular type of disability or need, for example:

- Adult Learning Disabled Association: adult learning disabilities
- BC Paraplegic Association: mobility impairments
- Canadian National Institute for the Blind: visual impairments
- Coast Foundation - PACT: psychiatric impairments
- Polaris: developmental impairments, mental illness
- Western Institute for the Deaf: hearing impairments
- Neil Squire Foundation: adults with highly specialized needs.
There are also organizations that are geographically-based such as the Powell River Model Community for People with Disabilities, which serves the Powell River Regional District.

Finally, there is a huge industry of private organizations that deliver services. Some of them deal with the whole vocational rehabilitation spectrum while others concentrate on specific components. The insurance-based companies (private insurers as well as ICBC and WCB) tend to use these types of services extensively.

3.4 Our research shows that little in the way of research has been conducted on the effectiveness of rehabilitation in BC, let alone comparative evaluation between or among different agencies providing rehabilitation.

3.5 Examples of evaluations and other related studies completed or underway include:


- The National Institute of Disability Management and Research (NIDMAR) (1997) report entitled Strategies for Success, which explores the implementation of different disability management programs in the workplace and presents a collection of case studies that describe the successes of disability management programs. In BC these include: ICBC, BC Hydro, TimberWest Forest Ltd. and Manulife Financial. (WP448)

- NIDMAR’s submission presenting recommendations to the Royal Commission (WP451) cites successes achieved by MacMillan Bloedel at its Somass sawmill and the Alberni Specialities Division.

- The Provincial Rehabilitation Planning Process’s reports including What the People Said (November 1995) and Improving Rehabilitation Services in British Columbia (November 1995). (WP354)


- Vocational Rehabilitation Services of the Ministry of Advanced Education, Training and Technology is evaluating its rehabilitation services in BC.

Appendix 8 presents brief outlines of the completed studies listed above.

3.6 Evaluation is planned for the future. Two examples we are aware of are:

- HRDC cost-sharing agreements with all provinces and territories; evaluation is a key element in these agreements.
• The BC Teachers’ Federation was, at the time the research was conducted, considering a pilot to determine whether vocational rehabilitation will improve return to work outcomes for its members.

3.7 Analysis of the reports from completed studies (Appendix 8) suggests that it is difficult to compare between different rehabilitation funders within the province, because there are differences, sometimes subtle, that may have a major bearing on outcomes. For example, small differences in eligibility criteria such as age limits could have significant impact on outcomes, given that even able-bodied older workers tend to have more difficulty finding work and some older clients may opt for early retirement.

3.8 Mandatory vs discretionary: As far as we can determine, all vocational rehabilitation in BC is discretionary. Participation on the part of the injured individual is voluntary.

3.9 Basis for claim: ICBC, and presumably some private insurers, operate under tort law, whereas the Workers’ Compensation Act provides no fault coverage, freeing employers from the threat of being sued. Whether or not the organization becomes involved in court cases appears to have an impact on several aspects of vocational rehabilitation, including the delivery method, the timeliness of services and the motivation of the injured individual.

3.10 Eligibility: All the funders set eligibility criteria that potential clients have to meet. ICBC, for example, limits certain personal damages, including access to vocational rehabilitation, to cases where the objective evidence of physical injury is apparent. The ‘no crash-no cash’ policy places the responsibility for rehabilitation for individuals with minor disability solely on themselves.

3.11 Range of services provided: The vocational rehabilitation services provided by the WCB are similar to those provided by other organizations in the province. Not all providers, however, offer assistance with small business start ups.

3.12 Delivery mechanisms: ICBC has chosen to have all vocational rehabilitation services delivered by external providers, primarily to maintain independence when the organization becomes involved in court cases. WCB and others use a mix of internal and external providers, with the main emphasis on internal staff. The NVRP evaluation noted that the question is to find the best balance between internal and external service providers: the WCB faces a similar challenge.

3.13 Costs: Most agencies in BC see their costs rising and view vocational rehabilitation as a way to reduce or curtail costs.

3.14 Outcomes and Performance: We found very little in the way of performance measures with respect to vocational rehabilitation. The figures that are available for returns to work cannot be compared for methodological reasons; for example, they may deal with different populations. The NVRP, for instance, was an expanded pilot, with small numbers and voluntary participation. The only study with clean data for the WCB
concerns back-injured workers. While we cannot directly compare the outcomes from these two studies, we note that some findings are similar. For example, the NVRP identified the need for better tracking of long-term impacts, which is a need the WCB also has.

An interesting observation from the NVRP evaluation is that even clients who had been out of work for a long time and who had waited a long time before going to rehabilitation got some good results. A similar finding on a much smaller sample came from the RTW-RTB pilot.

One interviewee noted that the private sector must be competitive: it cannot raise premiums at will, as customers shop around. They will compare what one company offers with what another offers and, all other things being equal, will likely choose the cheaper premium.

The same interviewee noted that private insurance companies tend to be much smaller than either the WCB or ICBC. Thus, the private sector cannot achieve the same economies of scale. At the same time, it does not have the same kind of bureaucracy to manage. ‘Those in the private sector can “turn on a dime”, but large corporations like ICBC and WCB, with their big engines, cannot.’

3.15 **Client satisfaction:** Responses from clients to the NVRP evaluation survey were similar to those from the WCB’s evaluation of back-injured workers, and to those found in the submissions of injured workers to the Royal Commission.

3.16 **Communications:** The need for better communications with stakeholders — injured individuals, assessment/premium payers (e.g. employers for WCB, individual motorists for ICBC), and even the general public — is common among virtually all organizations.

3.17 **Appeals:** In most instances, e.g. ICBC and private insurance, individuals have a responsibility to contribute to the cost of the appeal or review system. In the workers’ compensation system, in contrast, workers make no direct payments to the Board for these services. Since there are no fees for filing an appeal at any level, the administrative costs of appeal are borne by the whole system rather than the individual. (WP104b, p.80) This may have an impact on the number of appeals that are filed and the timing of those appeals. As appeals introduce an adversarial underpinning as well as extending the time for settlement, this could have an impact on the provision of vocational rehabilitation and the likelihood of its success.

**MEDICAL REHABILITATION**

3.18 In a 1994 presentation to the Senior Executive Committee, the then Director of the WCB’s Rehabilitation Centre noted:

‘Systematic clinical case management is an effective method of improving the quality of care and reducing costs. Such an approach is being implemented by ICBC. The ICBC
approach promotes a client-oriented pro-active approach to recovery. It is designed to
foster early recovery, reduce chronicity, reduce costs, reduce long duration claims, while
still fulfilling ICBC’s legal obligations. The ICBC program illustrates the application of
current best practices knowledge in a litigious insurance milieu.’ [Note: the research team
was advised this program was not yet underway at the time of data collection.]

3.19 The report ‘What the People Said: Planning for the Future of Rehabilitation Services in
British Columbia’ was a product of a provincial consultation and planning exercise in
1995.

Stakeholders identified the following issues that needed to be addressed first: lack of
integration and coordination across and within rehabilitation services; need for better
management of the transitions between acute care and the community and between age
groups; lack of services for specific populations; and inequities in resource allocation.

Goals were developed to guide in planning. These were: integrated and coordinated
rehabilitation services; users and providers together ensuring responsible use of
rehabilitation resources, effective management of services, and fair and effective
allocation and access to rehabilitation resources.

Included in the list of actions to meet these goals were: implement coordinated regional
and provincial planning; increase role of users in governance and planning for delivery of
rehabilitation services; develop and implement case management; improve inter-
ministerial coordination; develop and implement rehabilitation information systems;
establish a framework for allocation of resources; develop an effective equipment
distribution system; and initiate and expand outcome research and program evaluation.

Points of interest for the WCB are the support for case management and the recognition
of the need for improved information (e.g. systems and research). The tone of the
document is more collaborative between the clients and the providers, rather than the
adversarial tone of many WCB documents. This can be seen in the use of language such
as client/family centred care, shared responsibility, user participation in policy,
governance etc. (WP331)

3.20 The Rehabilitation Framework Development Sessions' participants developed a set of
principles for planning rehabilitation services which included: client/family centred care;
holistic care; shared responsibility; user participation in policy, governance, and service
delivery; continuity of care, accessibility; service delivery according to need; cost
effective; and driven by values, not by self or special interests. (WP331, p.5-6)
4 HOW DOES THE REHABILITATION PROVIDED BY THE WCB OF BC COMPARE WITH THAT PROVIDED BY (SELECTED) OTHER WORKERS’ COMPENSATION BOARDS?

The Comparative Review of Workers’ Compensation Systems and Governance Models conducted by Perrin and Thorau on behalf of the commission (WP168) includes information on vocational rehabilitation activities, medical services, rehabilitation facilities and psychological counselling. In this section, we compare the data presented in Perrin and Thorau with respect to all of Canada, four states in the USA (Michigan, Oregon, Texas and Washington), four jurisdictions in Australia (Comcare which serves federal employees, New South Wales, Queensland and Victoria), and the systems in Germany, New Zealand and Sweden.

In addition, Appendix 9 presents more detailed information on Germany, Australia (Comcare), New Zealand, the US, Oregon, Texas, Wisconsin and Washington. These data come from a variety of sources and illustrate some of the major differences among the various systems.

One issue that affects many workers’ compensation boards, not just the BC board is data capture and comparability. ‘Benchmarking’, the Administration of Workers’ Compensation Systems 1997 report notes: ‘A case in point is measuring return to work. This is clearly one of the most important benchmarks for the workers’ compensation system, but is exceedingly difficult to measure, especially on a uniform interstate basis. Even states with sophisticated data systems (e.g., Florida, Texas, and Wisconsin) have spent hundreds of analyst hours trying to measure it. Comparing states raises dozens of intractable definitional issues.’ (WP205, p. 3)

The California Department of Industrial Relations in its third anniversary report on workers’ compensation reform noted: ‘The lack of a comprehensive data information system has made it difficult to gain an overview of how the workers’ compensation system is working, where the problem areas are, and what the solutions to these problems could be. As a result of legislative mandates contained in the reform, DWC is currently developing a proposal for a workers’ compensation information system which would provide data needed to monitor the performance of the entire system and evaluate the effects of policy changes when they are made.’ (WP216, p. 49)

VOCATIONAL REHABILITATION

4.1 136 nations worldwide provide workers’ compensation. There are several models used, from state monopoly to fully-private; from a separate organization, to complete integration within the other social and health systems. (WP266a tab 1 p.7)

Australia, the US and Canada have a federal system in which the provinces/states play the major administrative role in the work-injury programs for private sector employees. In other countries such as Germany and Austria, work-injury programs grew out of arrangements that trace their origins to medieval times. The programs are administered and financed through industry-labour associations which are supervised by government at both regional (lander) and national levels. In the Netherlands, the joint industry-labour associations are also important (the ‘social partners’) but they have developed their own
administrative arrangements with the formation of the Joint Medical Services. Formal control is maintained by the associations and the whole arrangement operates under governmental supervision in accordance with the social insurance laws. (WP275, p.1)

4.2 The relationship between workers’ compensation and other social insurances varies. In some countries e.g. Netherlands and UK, the work-injury program is an integral part of the general social insurance program. In Belgium the program was privatized in the late 1980’s. In other countries, the work-injury program is administered as are the social insurances generally, but it is separately financed. Completely separate work-injury programs exist in the US, Canada, Finland, Australia and New Zealand, yet each is quite different, particularly as regards financing.

Separate work-injury programs have been discontinued in some countries — but elsewhere, for example in Canada and the US, they thrive. (WP275, p.2)

4.3 The method of financing also varies. In Finland, the basic State programs in US, Australia and partially in Switzerland, private insurance carriers are the main source of financing and they play an essential role in the administration of the program. In Canada, some states in Australia, Japan and New Zealand, a separate fund is reserved solely for the payment of work injury benefits. For the most part these funds operate like insurance carriers in that they are self-sustaining. They may be operated on a ‘pay as you go’ basis or be fully funded. In some countries, the program is financed through contributions from general governmental revenue. (WP275, p.3) The method of funding may well affect the extent of vocational rehabilitation that is made available to injured workers, although we were not able to identify any specific research in this area.

4.4 Within the various systems, each country’s rehabilitation program is, as Berkowitz noted, a product of its own history and culture; each nation has developed its own methods of determining disability. No country’s work-injury program stands apart from its other social and private insurance programs. Each country/program has its own social insurance laws, staffing, methods of administration and relationship of the system to the general laws of the land — and these affect how a particular rehabilitation system works. (WP275)

4.5 Some rehabilitation programs are concerned with work injuries in all aspects, ranging from medical care to eventual return to work; they may set fee schedules for physicians, monitor medical care, pay benefits, adjudicate disputes and administer a return to work program. In other jurisdictions, these responsibilities may be separated. In yet others, some may be absent. (WP275, p.5)
4.6 The different ways in which work-injury programs are organized define different tasks for administrators and pressures imposed on them, and may have a different practical effect on the disabled worker. For example:

- work-injury programs that are separate and apart from other social insurance programs have a good deal more visibility;
- visibility and possibly public scrutiny increase if the program is financed by employer levies, which respond quickly to increases in program costs; and
- return to work programs may be influenced by the way in which the administering agency is organized; there may, for example, be incentives that influence the behaviour of administrators. (WP275)

4.7 These variations coupled with the fact that different systems include/exclude different injuries and illnesses compound the problems in making comparisons. For example, Japan excludes back injuries from its workers’ compensation. (WP266d p.14) Many of the most intractable vocational rehabilitation cases in BC involve persons with back injuries. Thus comparing Japan with BC in terms of rehabilitation outputs is meaningless unless those with back injuries are excluded from BC’s figures. This research project has not had the resources to perform such analyses. The comparisons made below are taken from existing studies and descriptions of programs and outcomes.

4.8 Workers’ Compensation Boards in Canada are relatively homogeneous. Major differences among them, in terms of rehabilitation, concern the number of occupational diseases covered and their impact on rehabilitation, the use of case management and the existence of duty to accommodate legislation.

4.9 The WCB of BC’s strategic plan notes that ‘the primary roles and objectives of the organization are similar to those of other WCB’s in Canada and around the world. Each system, however, is a product of its unique environment. In developing this proposed solution, the strategies of other jurisdictions were examined.’ ‘Some jurisdictions have decided to change legislation drastically to reduce benefits, re-introduce waiting periods, or lower/freeze assessment rates. Others have added staff or privatized services. Still others have restructured programs, changed accounting assumptions or developed other unique programs of managed care ... and RTW initiatives. This diversity has provided the Board with a range of options to consider. The recent (1996) Administrative Inventory also objectively compares our performance to benchmark operations and identifies opportunities for improvement. The Board believes the proposed strategic plan incorporates some of the best practices in workers’ compensation.’ (WP3, pp.15-16)

4.10 Separation vs integration and governance: Fully two-thirds of the 136 nations with workers’ compensation laws include coverage within the general social service system, with relatively little distinction between work-related and non-work related injuries and illnesses. Only 10 (7%) workers’ compensation systems worldwide are like Canada in that they require government provided workers’ compensation insurance. Only 3 nations, including Canada, use a decentralized administrative structure. So Canada is not the norm worldwide. (WP266d, p.117)
4.11 **Percentage of workers covered:** Canada is among the minority of nations not providing full coverage to all employers for work-related injuries. The trend has been to extend mandatory coverage to all workers except the self-employed. (WP266a, tab 2, p.10)

With approximately 90% coverage of workers in the province, BC is not as complete in its coverage as Saskatchewan (100%), but is comparable to most other Canadian provinces and more extensive than Alberta (80%), Ontario (70%) and Manitoba (63%).

4.12 **Goals and objectives of vocational rehabilitation:** Workers’ compensation boards in virtually all North American jurisdictions have established funds or legislation to provide injured workers with vocational rehabilitation services. These services are typically directed toward permanently injured workers. Broadly speaking, the goal is thought to be achieved by returning the injured worker as soon as possible following the injury to an occupation and lifetime earnings profile that most closely approximates what the worker would have experienced in the absence of the injury. (WP38, p.158) BC fits within these generalized goals and objectives.

4.13 **Mandatory vs discretionary nature of vocational rehabilitation:** In most of Canada, as in BC, vocational rehabilitation is discretionary. It is mandatory in Quebec, as well as in some US states, Australia and New Zealand. It was mandatory in Washington, but that requirement was repealed due to rising costs without the concomitant improvement in return to work rates. Ison in ‘Workers’ Compensation in Canada’ (p.144) argues that ‘it is at least doubtful whether [rehabilitation assistance being to some extent a statutory right in Quebec] creates any advantage for workers.’ ‘Exactly what assistance will be provided is still largely discretionary, and it is arguable that the statutory “right” to rehabilitation may be a negative influence on compensation. It was enacted as part of the trade-off for the abolition of pensions for permanent disability.’

4.14 **Insurance vs traditional model:** The Liberty study reports a frequently expressed notion that the workers’ compensation system has moved away from being an insurance system and toward being another social assistance program. (WP266a tab 3, p.3) BC would appear to be somewhere between these two extremes.

4.15 **Range of vocational rehabilitation services provided:** In terms of the variety of rehabilitation services available, BC is among the most generous in the world. In addition to providing all the common services, it also provides (as a last resort) assistance with business start-ups. As far as we can determine, no other WCB offers this service. This could be interpreted as very, even overly, generous, or as anticipating the change occurring in the workplace, where self-employment, in BC at least, is rising and now accounts for over 20% of total employment in the province. (WP295, p.i)

4.16 **Delivery mechanism:** The options are fully internal, fully external or a combination. BC is similar to many other jurisdictions in its combined use of internal staff and external specialists.
4.17 **Case management:** Case management is already in place in the WCB’s in Alberta, Saskatchewan, Newfoundland, New Brunswick, Nova Scotia and PEI. Manitoba has separated initial and ongoing adjudication services, renaming the latter case management, but has not integrated decision-making authority for medical services and vocational rehabilitation into the case manager’s role. In terms of implementing case management, BC is somewhat behind most other Canadian jurisdictions.

4.18 **Performance:** The analysis of the Administrative Inventories conducted for the Royal Commission noted that the inventories do not generally provide information on how the WCB of BC compares with other jurisdictions in terms of performance. (WP102a, p.iii) Our research also found very little comparison with other jurisdictions. A likely reason for this is the methodological constraints presented in Issue 2 above in the discussion on effectiveness of rehabilitation.

One Ontario study shows that 39.3% of those participating in a vocational rehabilitation program returned to work, compared with 90.6% of those who did not participate in such a program. (WP38, p.169) By comparison, the 1994 Evaluation of back-injured workers at the WCB of BC found that 59% of those who received services reported that they had returned to work during or at the same time as their vocational rehabilitation interventions finished. (WP20, p.51) However, without much further analysis to ensure that comparable populations are being examined, similar definitions being used, etc., it would be foolhardy to conclude that BC is performing significantly better than Ontario.

A survey of Canadian workers’ compensation jurisdictions conducted by Nexus Actuarial Consultants for the WCB of BC includes a table that summarizes performance measures, whether they are considered to be key outcome measures, and whether they are currently collected/calculated. While none of these related directly to rehabilitation of any kind, there was some information regarding long term disability (LTD) claims and returns to work. The survey found: ‘There are a number of measures that most (if not all) jurisdictions consider to be key outcome measures and yet very few jurisdictions collect. Most significantly:

- The number of LTD claims where worker returns to pre-injury employer with either:
  - job modified;
  - job unmodified; or
  - alternative job.’

The same appears to be true of short term disability claims (STD). The exceptions are Newfoundland (both LTD and STD) and New Brunswick (STD). (WP297, p.27)

Given this situation, we suggest that it is unlikely that these organizations collect information on similar job status after rehabilitation.

4.19 **Costs and cost-effectiveness:** The WCB’s 1994 Evaluation noted that it was not possible to determine the cost effectiveness of vocational rehabilitation for back-injured workers.
The WCB of BC is moving towards being able to calculate cost effectiveness, as indicated in the 1998 business plan; however, the information does not yet exist.

The WCB’s Business Case Financial Summary notes that BC’s case management cost/benefits cannot be compared with those in other provinces due to differences in legislation frameworks and the case management models used. (WP113a, appendix F, p1)

Thus, we are unable to compare BC to other jurisdictions in terms of costs and cost-effectiveness.

In its discussion of various US models, the Liberty study notes: ‘While no statistical correlation relating financial results of a system to specific benefit or cost parameters is evident, a comparison of several key variables ... indicates that states with monopolistic state funds (like Canada’s) tend to have higher losses per worker and place a greater burden on employers via premiums than their privately insured counterparts.’ None of the variables were specifically rehabilitation; it is not clear whether rehabilitation benefits were included in benefits generally. (WP266d p.1)

4.20 Data management: Problems with data capture are not unique to the WCB of BC. ‘A case in point is measuring return to work. This is clearly one of the most important benchmarks for the workers’ compensation system, but is exceedingly difficult to measure, especially on a uniform interstate basis. Even states with sophisticated data systems (e.g., Florida, Texas, and Wisconsin) have spent hundreds of analyst hours trying to measure it. Comparing states raises dozens of intractable definitional issues.’ (WP205, p.3)

From California: ‘The lack of a comprehensive data information system has made it difficult to gain an overview of how the workers’ compensation system is working, where the problem areas are, and what the solutions to these problems could be. As a result of legislative mandates contained in the reform, DWC is currently developing a proposal for a workers’ compensation information system which would provide data needed to monitor the performance of the entire system and evaluate the effects of policy changes when they are made.’ (WP216, p. 49)

4.21 In recent years, the WCB of BC has undergone enormous change. That change is still on-going. In this regard, BC is no different than many other workers’ compensation systems worldwide.

The Liberty study notes that workers’ compensation systems in many countries are facing similar problems and many have either undertaken or are in the process of making significant reforms to their systems. These reforms are driven by complex and competing interests, financial strain and changes in the workplace. WCB’s are breaking new ground in several areas. (WP266a tab 1 p.3, 8) ‘Our studies of workers’ compensation systems in Canada, the US, Europe and Australasia have impressed us with the rate of change that is taking place in a very complex and arcane area of human services. This unfolding change is a response to two different objectives which, from time to time, conflict in the
conduct of workers’ compensation affairs; firstly, the human dimension of reduced pain and suffering, physical and mental rehabilitation and timely return to work with appropriate compensation in the off-work period, and secondly, the economic dimension of a financially sound insurance scheme with affordable assessments and a fully funded plan.’ The study notes that while different jurisdictions have tried different strategies to balance these sometimes conflicting objectives, there does not so far appear to one strategy that is optimal for everyone. (WP266a tab 2, p.7)

**MEDICAL REHABILITATION**

4.22 In 1994, the then Director of the Rehabilitation Centre noted: ‘In 1991, the American Academy of Orthopaedic Surgeons began a consensus building process concerning medical issues in Workers’ Compensation. They identified 38 high priority problems, and recommended 48 solutions. The recommendations emphasized six categories of action that are constructive to solving medical problems associated with Workers’ Compensation:

- practice guideline development
- temporary modified work
- education (involving all stakeholders)
- prevention
- patient advocacy
- legislative and regulatory changes.’ (SEC presentation Dec. 1994, p.2)

4.23 The Rehabilitation Services Inventory and Quality Project, Phase Two Report addresses three dimensions of quality in rehabilitation: consumer satisfaction, efficiency and effectiveness. The recommendations developed to improve the quality of rehabilitation services in Ontario were:

1. Research into the effectiveness of involving consumers and their families in the process of rehabilitation — assessment, planning, goal-setting, implementation, and follow-up — should be undertaken.
2. Opportunities for interdisciplinary understanding among health professionals should be increased in educational settings, and up-to-date information about common rehabilitation treatment procedures should be readily available to individual professionals.
3. Consumers should have ready access to up-to-date information about common rehabilitation treatment procedures and what to expect from the different health professions.
4. Consumers’ levels of satisfaction with different rehabilitation facilities should be monitored and measured using validated common tools.
5. Once there are validated measures of consumers’ levels of satisfaction with rehabilitation facilities, the review results should be reported publicly.
6. To guard against price distortions in the rehabilitation services sector, the payers for rehabilitation services should meet regularly, share information about the
services they are buying and co-ordinate an approach to the prices they are paying.

7. Standardized resource utilization measures should be used to report on rehabilitation services provided in the province.

8. Research should be undertaken to determine when and in what circumstances case managers are cost effective. A separate but related issue — the advisability of regulating case managers — should also be addressed.

9. Information about the kind of rehabilitation research currently under way in Ontario and other appropriate jurisdictions should be collected. Subsequently, gaps in current research efforts should be identified, together with sources of funds for new research.

10. Existing funds for rehabilitation research should be prioritized and new sources of funds should be identified.

11. Drawing on worldwide rehabilitation research, consensus guidelines based on evidence should be developed and implemented for a priority list of rehabilitation services. Where existing research is inadequate to develop guidelines, original research aimed at ascertaining best practices should be commissioned.

12. Differential access to rehabilitation services continues to be identified as an issue. Major payers in the rehabilitation sector should, for a defined pilot period, monitor access to a range of rehabilitation services with respect to certain condition-specific treatments. The Ministry of Health should then determine whether the current system is appropriate and deal reasonably with exceptional cases.

13. The Government of Ontario should designate a lead ministry or agency to develop the next steps to improve the quality of rehabilitation services in the province. It should take the lead to promote action to develop best practice guidelines, coordinate approaches to pricing, consider issues around accreditation, establish research priorities, and determine whether current differential access patterns are appropriate. (WP334)

4.24 The Alberta WCB Medical Services Manuals states: ‘Alberta WCB Medical Services has produced three sets of guidelines as a service to support health care providers and case managers who care for injured workers. These guidelines will be constantly revisited and adjusted as new medical evidence becomes available. Objectivity and validation from the medical community is key to their development and maintenance. The Medical Advisory Guidelines have been developed to ensure that Alberta WCB Medical Advisors have access to the most current medical information and research on specific conditions and can provide consistent advice in the support of case management. It is anticipated that they will also be a useful tool for health care providers in Alberta as they care for injured workers. The Medical Advisory Guidelines Manual includes guidelines and background papers on:

- acute low back pain;
- repetitive strain injuries;
- fibromyalgia/myofascial pain;
• whiplash; and
• temporomandibular joint disorders.

Additional background papers and guidelines are currently under development and will be distributed when they have been validated. Duration Guidelines give guidance to case managers and health care providers as to the average time required for workers to return to work after various work-related injuries and treatments. Duration guidelines are included as a part of the Medical Advisory Guideline Manual; they are also available as a separate document. The Alberta Permanent Clinical Impairment Guidelines are a descriptive guide to the process used by Alberta WCB to assess permanent clinical impairment from the loss of use of, or derangement of any body part, system or function due to a compensable accident. Alberta Permanent Clinical Impairment Guidelines are included in WCB Compensation Manuals; they are also available as a separate document.’ (WP427, p.1)

4.25 An article in the May 1996 edition of Alberta WCB’s organ, The Communicator, entitled ‘Changing the way we manage health care’ states: ‘Continuum of Care Models outline standardized approaches to health care treatment for specific categories of injuries. These models identify the most appropriate type of treatment at various stages in the healing of an injury. They are designed to assist the case manager in health care decisions, ensuring consistency and quality while moving the injured worker steadily toward recovery. “Continuum of Care models are great communication tools,” says Sally Nikolaj, Health Care Services manager, “they act as a kind of road map, identifying which health care providers we need, when we need them and how long their services are required.” Initial emphasis has been placed on the model for management of the soft tissue injuries since this type of injury represents approximately 60 per cent of total WCB claims.’ (WP428, p.1)

4.26 A May 1997 article from the Alberta WCB entitled ‘New Rehabilitation Program To Begin May 5′ states: ‘A recent evaluation of Work Hardening and Pain Management Programs demonstrated the need to modify the delivery of these services to better meet the needs of injured workers and the WCB. In response to this, on May 5, 1997, the Occupational Rehabilitation Service Delivery Model will be introduced at the WCB Milliard Rehabilitation Centre and WCB authorized providers. This model is specifically designed to identify individual client needs, and to ensure the appropriate level of service is provided. It will also ensure improved communication between service providers and case managers to successfully resolve claims. At the WAC, clients will be assessed, resulting in one of the following determinations:

1) client is determined Fit to Work;
2) client requires medical rehabilitation; or
3) client requires occupational rehabilitation.

Clients requiring occupational rehabilitation will receive the level of service that meets their specific needs. Case managers, WCB Millard Rehabilitation Centre staff and authorized providers have already begun to modify their work processes to meet the
needs of the new OR model. As the new program evolves, responsibilities and requirements will be reviewed and adjustments made if necessary.’ (WP162, p.1)

4.27 The Liberty review of workers' compensation in Canada concluded that ‘the concept of managing care has the potential to be a contemporary model for workers' compensation in Canada. As noted earlier, it is important to reinforce that managing care is not a cost containment strategy, per se, although it has that beneficial effect as a natural outcome. Its principal focus is to achieve more effective results for the two key stakeholders and quality and investment concepts to achieve a range of pre-determined outcomes. This approach may result in efficiencies and, thus, be less costly. But that is a by-product of an approach whose prime focus is on benefits. In this light, the concept is the centrepiece of care reform measures which are the foundation for WCB reform generally.’ (WP266a, p.15)

4.28 In a 1994 presentation, the then Director of the Rehabilitation Centre noted that in March 1994, the Workers’ Compensation Research Institute held a conference to determine what works to control Workers' Compensation medical costs. Six major opportunities for cost savings were identified:

- fee schedules
- provider networks
- utilization management
- health maintenance organizations and capitation
- cost sharing
- practice guidelines.’

4.29 A 1995 review of International and Jurisdictional Best Practice in Return to Work noted: ‘successful workers' compensation operations are characterised by a high level of managerial responsibility and accountability. At the enterprise level this is shown in the practices of leading corporate groups such as DuPont, Xerox and Control Data, where workers' compensation is treated more as a general employee welfare issue than as one of legal entitlement. Such groups have been at the forefront of transcending the work/non-work injury divide and taking a proactive, wellness, approach to employee health and welfare. At the workers' compensation system level, the better performing schemes such as Wisconsin, Washington State and British Columbia all exhibit the characteristics of strong managerial oversight, whether it be of a largely monitoring or facilitative role (as in Wisconsin) or highly interventionist in nature (as in Washington State).’ (WP342, p. 1)

**Psychological Rehabilitation**

4.30 A 1995 Psychology Department report showed that at that time, only 4 of 12 Canadian provinces and territories offered psychology services through the WCB. They were BC, Alberta, Ontario and New Brunswick. (WP383, p. d1) Since that time, Manitoba, Newfoundland, NWT, PEI, Quebec and Yukon (limited) have to be added to that list. New Brunswick appears to no longer offer such counselling.
4.31 The Liberty study reports that compensation for stress related physical and psychological disabilities has become a central topic in workers' compensation. ‘We heard the view expressed that the struggle to address this issue exposes the flaws of the present system, which focuses on the injuries and diseases arising directly out of and in the course of employment, and which did not contemplate impairments or disabilities which arise gradually and over time. This suggests that the workers' compensation system will have to undergo some re-engineering to address the issues arising out of the evolving work environment and the concomitant tensions that are introduced into the work/family nexus.

There was a great deal of diversity among some of those we consulted on the "philosophy" of compensating stress related claims, just as there is diversity across jurisdictions on current policy. The differences relate, at least in part, to whether mental-mental stress (i.e., stress not related to an "accident") should be compensated at all, and whether any or which non-work factors should be included in determining the extent to which stress is attributable to the workplace.’ (WP266a, p.11)

4.32 Worker's compensation boards in most jurisdictions are being asked to adjudicate a growing number of claims for work-related psychological disorders such as stress. As noted in Section 2 above, the Association of Workers’ Compensation Boards of Canada has provided a concise statement on the current compensation policies for psychological disorders. The following shows the extent to which workers’ compensation systems deal with claims in each of the three broad categories of psychological disorder:

‘At the current time, all Canadian WCB's will provide compensation to workers for "physical-mental" claims, whereby the nature or treatment of a compensable physical injury has led to psychological problems. They will also provide compensation for "mental-physical" claims, or those in which a stressful work environment has lead to physical symptoms, such as a heart attack. However, these claims have generally been rare because it is difficult for claimants to establish that their workplace significantly contributed to the development of their physical impairment or illness. Most Boards will not provide compensation for "mental-mental" claims, or those in which the claimant alleges that he or she has developed a mental condition as a result of a psychologically debilitating work environment. The only exception to this general rule is if the worker experienced an identifiable mental trauma, or a series of such traumas, and when viewed objectively, this could have produced a mental disorder.

‘In reviewing policies related to psychological disorders, Boards are having to re-evaluate their traditional definitions of what constitutes a disablement arising out of and in the course of employment. A key question is whether the definition should encompass chronic injuries that gradually emerge over time, and not just those that occur suddenly.

‘Draft policies which contain the spirit of a broader definition have begun to be circulated to stakeholders by a number of Canadian Boards as a part of a consultation process. While Boards have yet to finalize their policies, a document circulated by the Ontario Workers' Compensation Board reveals some key considerations.
‘Criteria for establishing whether a worker has suffered a compensable chronic workplace stress disorder, and a determination that the psychological disorder arose out of and in the course of employment. That is, there will need to be established both a medical connection and an employment connection. The employment connection could be established if workplace stress was a significant contributing factor to the development of the condition and the medical connection could be established if the diagnosed psychological disorder is compatible with the workplace stressors and that the condition would not have developed, within the same time-frame, without the employment contribution.

‘One of the most controversial aspects of compensating psychological disorder is inquiry into the non-work related stressors faced by the worker. Such inquiry would may be necessary when there is a reason to believe that non-work related factors have contributed to the worker's condition.’ (WP266e, p.55)

4.33 The Liberty study also notes that ‘Compensation for psychological disorders has been met with trepidation by Boards and employers because of the potential cost implications.’ Those active in the debate in stress compensation are aware of the California experience. The Association of Worker's Compensation Boards of Canada reports that, following a California court ruling that stress was compensable, stress claims increased by 700 percent over the following ten years. This compares to a 25 percent increase in all other claims. (WP266e, p.55)

4.34 From New Zealand: ‘Stress claims are a major cause of escalating costs in those overseas workers' compensation schemes that compensate for stress. The present scheme does include stress cover and the Working Party considered that this should not change. Grounds for this conclusion were not only the high cost, but also that stress is the result of a number of interrelated factors. The Working Party also recommended that physical injury should be present before mental injury is covered. Although this may give an appearance of arbitrariness, this requirement was seen as necessary in order to avoid stress claims entering “through the back door”. The Government supports this view. The question as to whether an exception should be made in the case of criminal injury remains. Stress and Mental Injury Will Not Be Covered Unless Physical Injury Is Present.’ (WP238, p.32)

4.35 From Wisconsin: Injuries covered by the law include:

- Mental harm including nervous disorders, hysteria, and traumatic neurosis. The effects of brain hemorrhage caused by an industrial accident may also result in harm. If the injury is mental harm or emotional stress without a physical trauma, the injured employee must show that it resulted from a situation of greater dimensions than the day-to-day mental stresses and tensions which all employees experience.
- Accidental injury such as physical or traumatic mental harm occurring suddenly and unexpectedly as a result of some employment-related activity.’ (WP200, p.3)
5. WHAT IS THE TRUE COST OF PROVIDING INJURED WORKERS WITH REHABILITATION? DO THE BENEFITS OUTWEIGH THE COSTS?

VOCATIONAL REHABILITATION

5.1 Our research found very few references to detailed information on costs, and even less on cost-benefit analysis.

5.2 The National Institute of Disability Management and Research (NIDMAR) notes that disabling injuries and illness have enormous personal, social and economic effects that are rarely fully recognized or understood.

Direct costs can be measured by healthcare or rehabilitation costs, lost time from work, the costs of assistive devices, insurance premiums etc.

Indirect costs are less obvious and may be impossible to measure empirically. They might include the decrease in productivity caused by the loss of an experienced worker, the loss to the tax system as a disabled worker is placed on a life-time disability pension, and the increased demand on social services as unemployed persons with disabilities struggle to cope with reduced economic circumstances. (WP441, p.1)

5.3 The research found some very high level statements that demonstrate the magnitude of rehabilitation costs. These are presented below, starting at the national level and moving to the provincial and then the individual, and ending with two international examples.

5.4 NIDMAR cites ‘conservative estimates’ that put the direct and indirect costs of occupational injuries and disease in Canada between $10 billion and $14 billion. These costs are limited to workers’ compensation systems. ‘When we factor in the overflow into other insurance and benefits systems such as CPP, EI sickness benefits, short-term and long-term disability programs, automobile insurance etc. the total impact on our economy is staggering.’ (WP451, p.12)

5.5 New NIDMAR research indicates that the direct and indirect costs of disability in BC amounted to $3.6 billion in 1994. Left unchecked, these costs could soar to $30.5 billion by 2006. Overall disability costs account for eight cents of every dollar earned in BC. (WP451, p.12)

5.6 Improving Rehabilitation Services in BC, the summary report of the Provincial Rehabilitation Planning Process (WP354, p.10) noted that: ‘A minimum of $121,000,000 was expended upon direct rehabilitation services in BC in 1992/93. The rehabilitation system payers include:

- provincial government (Ministries of Health; Skills, Training and Labour; Social Services and Education)
- federal government (Departments of Veteran Affairs; Indian and Northern Affairs; the military)
• ICBC
• WCB
• private insurance companies
• individuals.’

It is not clear what expenses this covers; the project appears to be concerned with medical rehabilitation and appears to exclude vocational rehabilitation — for example, CPP is not included in the list — although this is not stated.

5.7. In contrast, the evaluation of CPP’s National Vocational Rehabilitation Program was able to identify quite precise costs.

The costs of the project over the three-year operating period reviewed total about $3.5 million. Of these costs, about 65% was spent on rehabilitation costs (including professional fees for rehabilitation consultants and the costs of rehabilitation services provided to clients), 35% on staffing for the Rehabilitation Unit; and 5% on overhead.

The total number of NVRP clients served was 623, about 36% of whom were still in receipt of rehabilitation services and would require further expenditures before completion of their rehabilitation plan. ‘Given the large number of clients in progress, the precise cost per client for the project could not be determined at the time of writing.’

For those with a completion status, estimated per client costs were:
‘ceased’: rehabilitation costs: $4,739; management costs $1,942; total: $6,681
‘closed’: rehabilitation costs: $3,175; management costs $1,942; total: $5,117.

Total costs per rehabilitated client, which includes costs incurred for unsuccessful candidates and administration: $14,069.

The evaluation recognizes that per client rehabilitation costs in the $3,000 range are low.

‘The results show that total costs per client whose benefits were terminated after successful completion of a rehabilitation plan ($14,069) was less than twice the amount of the average annual pension ($8,760) received by NVRP clients, as reported in the survey. Thus, with current project expenditures, total project costs per rehabilitated client are recovered on average within two years after a client successfully completes rehabilitation’ provided that person does not return to the beneficiary rolls. (WP298, p.75)

In terms of benefits, the evaluation notes: ‘Many uncertainties remain about the ‘true’ potential cost-savings of a rehabilitation component as part of the CPPD. This is primarily due to the fact that longer-term impacts cannot be assessed at this point, so the need for tracking certain project outcomes, such as the capacity of former participants to sustain employment in the longer-term, is an important data need for future analysis.’ (WP298, p.77)
The report also cautions that ‘NVRP outcomes must be viewed in relation to the fact that CPPD beneficiaries are generally among the most disabled of individuals and generally have extensive rehabilitation needs.’ (WP298, p.79)

5.8 The NVRP also cites data from the United States (Zeitzer, Quality, effectiveness and efficiency of rehabilitation measures. International Social Security Association 25th General Assembly, Nusa Dua, 13-19 November, 1995, p.58) which indicate that total costs per rehabilitation client in the 1991-93 period has totaled approximately US$10,000. The evaluation points out that these data are not perfectly comparable to its own given that average rehabilitation costs are reimbursed to state vocational rehabilitation agencies for successfully rehabilitated beneficiaries only. No costs are incurred when beneficiaries are not successfully returned to work for a period of at least 9 consecutive months.’ (WP298, p.76)

5.9 The direct cost of workers’ compensation in Australia during the 1980’s was $5 billion annually. Indirect costs, such as the loss of productivity through lost time, lost skill and retraining have been estimated to be as much as four times the direct costs of workplace injury and disease. Time lost as a result of workplace injuries was estimated to be at least ten times the amount lost due to industrial disputes. (WP266d)

5.10 While the costs are difficult if not impossible to ascertain, the benefits are easier to list, although equally as difficult to place a cost on. NIDMAR comments:

When a worker with disabilities returns to work, everyone benefits:

- the worker retains earning capacity and a sense of self-worth;
- the worker’s family benefits directly both financially and emotionally;
- the employer retains an experienced employee who contributes to the overall productivity of the work force and avoids the costs and difficulties of hiring and training a replacement worker; and
- the economy benefits both from the retention of a productive employee and from the maintenance of a tax payer instead of a tax consumer. (WP451, p.12)

5.11 Despite the difficulties in determining precise costs, there appears to be consensus that in Canada and elsewhere healthcare and disability-related costs have increased exponentially, causing a serious re-evaluation of both public and private insurance schemes and reviews of the complexities and inefficiencies in existing networks of regulations, legislation and standards that relate to the treatment of persons with disabilities. (WP448, p.1)
5.12 In a presentation the then Director of the Rehabilitation centre noted that the most extensive and systematic study of the question how effective are physical activation work conditioning programs was completed by Mitchell and Carmen (1990).

‘They compared 703 Ontario compensation recipients, who received physiotherapy work conditioning program, to a comparable 703 who received regular treatment. Looking at the data up to the end of 1988, the entire work conditioning sample had a total days lost from work of 88,400. The comparison regular treatment group had a total days lost from work of 127,600.

‘Looking at cost effectiveness, the total cost, including both wage replacement and treatment costs for the work conditioning sample was $5,584,000, while the total cost for the regular treatment group was $7,155,000. Thus the work conditioning sample provided a net saving to the WCB of approximately $1.6 million in the treatment of 703 cases.

‘Two considerations ought to be noted about this cost benefit. First of all, compared to the substantial effect of policy on disability, the savings due to improved rehabilitation practices, while impressive, are still small compared to the impact of policy. Secondly, the Ontario sample only included those who attended treatment. It did not include those rejected from treatment, or premature treatment drop-outs. Thus a selection factor may be contaminating the findings. The higher costs accrue in the more difficult cases, not in the cases who are apt to return to work no matter what treatment they receive.’ (WP157, p.5)

5.13 In the same presentation, the then Director noted: ‘consideration of rehabilitation effects, provided by either private clinics or the WCB itself, leads to a second conclusion about cost containment: rehabilitation treatment is cost effective. The impact on cost is smaller than that of policy and must be carefully evaluated.’ (WP157, p.7)

5.14 The same presentation also asked the question: are multidisciplinary pain clinics effective? The then Director of the Rehabilitation Centre responded:

‘One has to keep in mind that the referrals to multidisciplinary pain clinics are the much more difficult cases, compared to those at a more acute stage of their injury, referred to community work conditioning programs. Systematic data on effectiveness has been collected for one chronic pain clinic in Vancouver. Referrals have a median time since injury of three years, and a mean of four. Average number of previous surgeries is two. Approximately 75% of referrals are addicted to large doses of narcotic analgesics at admission. At follow-ups, as long as five years, return to work rates after treatment are approximately 39%, compared to 13% in a non-treatment group.'
Similarly, costs are nearly twice as high for the non-treatment group compared to the treated group. For example, pension reserves, up to 1982, averaged $64,900 for the treated group, compared to $118,460 for the non-treatment group.

‘This data also raises key rehabilitation and cost effectiveness issues. First of all, the effectiveness of treatment so many years after the injury is about half that of the more acute work conditioning programs, even with the massive therapeutic interventions inherent in a chronic pain clinic. This underscores the well-know axiom in rehabilitation, that "earlier is better". Additionally, one can ask, given the financial benefit of treatment, even in this prolonged disability sample, why we have not been more aggressive in fostering pain clinics. The reasons lie in organizational and administrative issues, not in clinical results. So long as the referral system relies on individual staff preferences and opinions, a rational approach to clinical case management is impeded. Some staff simply do not believe the evidence. Others do not care about the evidence. Others hold personal opinions at variance with the evidence. Some staff do what they can to make reasoned referrals. Some are concerned about the cost of treatment (e.g. $1,700 per week for outpatient care to $16,400 for six weeks of residential treatment). All of these decisions are made in the pressure of high volume workloads. The importance of increased integration of clinical and corporate planning is self-evident.’ (WP157, p.5-6)

5.15 The Association of Workers’ Compensation Boards of Canada’s 1997 report Compensating for Chronic Pain notes: ‘The Board found that 65% of those treated received no workers' compensation benefits four years after treatment, suggesting that substantial savings could be attained as a result of treatment of chronic pain at pain clinics.’ (WP123, p.3)

5.16 Upjohn Institute for Employment and Research Technical Report No. 93-004, Disability Prevention Among Michigan Employers 1988-1993, indicates that research shows that roughly 50% of the costs that result from accidents depend on how the company responds to and manages injuries after they occur. ‘This was confirmed in the pilot study conducted in Michigan and published in 1991.’ (cited in WP336, p.2)

5.17 ‘Managed care is reported to be one of the predominant cost-control strategies in all health and disability-related areas except for workers' compensation. This divergence in utilization of managed care suggests that the amount of control over health care costs differs among health care, long-and short-term disabilities, and workers' compensation. Control over health care costs appears to be closely related to the variation in workers' compensation plans from state to state and the degree to which those laws allow managed care. Managed care's role in workers' compensation may also be changing. Recent legislation in California, Florida and Texas, for instance, expands an employer's control over medical treatment when a variety of medical care options, including managed care, are made available to injured workers.’ (WP140, p. 6)

5.18 In Florida, ‘In an effort to curb the growth of medical care costs, the legislature mandated managed care for workers compensation claimants, beginning 1997. Employers who enter into managed care agreements before this date can save up to 10
percent on their workers compensation premiums, an indication of the savings likely to accrue.’ ‘About half the states now allow workers to choose their own medical care provider but many workers in those states voluntarily choose to use medical care providers in a managed care network.’ (WP206, p.10)

5.19 ‘In California, employers have saved thousands of dollars as a result of sweeping changes brought about by a package of bills enacted in July, 1993. One estimate put the premium savings enjoyed by employers in 1995 at $1.9 billion, a 27 percent drop from 1994. The decline in California rates is also the result of deregulation. This change has led to intense competition among the state's more than 300 insurers, and growing competition between property/casualty insurers and health maintenance organizations that own workers compensation insurers.’ (WP206, p.9)

5.20 The 1996 Administrative Inventory stated: ‘In the United States, disability management techniques are being used to attack, apparently successfully, both the incidence and the duration of disability. It is true that the financial payoff accrues primarily to private employers and private insurance companies, but the injured worker gets back to making his or her living more rapidly, as well. Ultimately, it appears that this also leads to fewer cases of the self-defeating psychology of learned disability. In British Columbia, the incentives for disability management are very much attenuated...The WCB has the incentive, but because of the inefficiencies of linear processing, attends to the situation far too late in most cases to make a significant impact on recovery and return to work possibilities. The WCB needs to develop mechanisms to actively manage disability for the benefit of the injured worker and his/her employer. Only in this way can the true cost of disability be minimized for the benefit of the entire society.’ (WP18, p.258)

5.21 ‘The costs associated with health care utilization have, in some countries, risen faster that the rate of inflation (Cats-Baril & Frymoyer, 1991). Compensation costs in British Columbia have increased dramatically, primarily due to rising health care costs (WCB, 1993a). Age is a very strong predicator of LBP [lower back pain] and chronic disability, and will continue to be a major factor particularly in its impact upon the health care delivery system in the next decade (Frymoyer et al., 1991). More and more resources will be allocated to meet the needs of a progressively more aged population over the next few decades (Rybash, Roodin & Santrack, 1991). It is estimated that by the year 2005, the population in British Columbia will have increased by 1 million, most of which will be composed of people between the ages of 34 to 64 (Kunin, 1993).’ (WP409, p.7)

5.22 Health Care Issues Under the Workers Compensation Act, a briefing paper prepared by the Board for the commission, states:

“‘Managed care’ as practised in the general US health care system includes a number of mechanisms designed to limit utilization and costs of service. Examples are prior authorization review for certain procedures, obtaining a second opinion for certain procedures, case management, use of less costly treatment settings and procedures, selective enrollment, lifetime dollar limitations and limits on annual inpatient days and outpatient visits. However, the most common “image” of a managed care system is an
organization or network that has agreed to provide health care services, whether directly or through providers with which it contracts, at agreed to rates and in accordance with specified guidelines for the treatment of patients. There are several types of “managed care” organizations or networks. One of the most common is the Health Maintenance Organization (HMO):

'HMOs contract with employers or state agencies to provide a defined range of health care services for a pre-determined payment per insured. They generate cost savings through lower utilization rate physician costs, because fees are determined on a capitation instead of a fee for service basis. They employ a product line budgeting system which minimizes costs by limiting the resources which can be expended in treating any given health problem. If the total allowable cost associated with treating a particular patient exceeds the allowable rate, health care providers participating in the HMO must bear the burden of additional costs.’ (WP155, p.22)

'It is natural that, faced with the significant increases in workers' compensation health care costs, employers, insurance carriers, state regulators and others have looked to the “managed care” and other measures adopted in the US general health care system. As yet, however, there appears to have been little evaluation of the success of these cost containment measures or their effect on quality of treatment. Certain legal issues particular to the workers' compensation system, such as freedom of choice of health care provider and requirements that workers receive full medical coverage at no expense, have also to be considered.' (WP155, p.25)

5.23 ‘We discuss methods of spine rehabilitation that have emerged from experience with work-related disorders because they have the greatest implications to society. Specific socioeconomic outcomes, such as return to work, are of greater importance. A compensation environment ties financial benefits to medical benefits, which complicates responses to medical treatment. The reader should not believe that such influences are unique to workers' compensation. Compensation disability that is not related to work (private long-term disability, personal injury-related disability, Social Security Disability Income, etc.) and often hidden from the medical provider may produce psychosomatic behaviours detrimental to productivity and the cost of management. Design of modern spine rehabilitation is being driven by measures of outcome relative to costs. Such evaluations require mindfulness of quality of care. Long-term and multi focal reduction in costs follow quality care, although short-term or narrowly focused evaluations may not reflect savings.’ (WP211, p.2060)

**PSYCHOLOGICAL REHABILITATION**

5.24 A 1991 paper on Chronic Disability Syndrome notes: ‘The cost of disability is not measured in dollars alone. There is an enormous human cost to disability. The loss of self worth results in marital and family stress. Finances are strained. Depression is endemic. Alcohol and drug problems are common. Many become angry and bitter. This can be referred to as chronic illness behavior. These changes can become more disabiling than the initiating injury. Social factors can compound disability. Increasing age, poor
education, lack of transferable skills, and heavy labouring occupations all tend to limit the success of rehabilitation efforts. Even job satisfaction has been shown to be a significant factor in chronic disability.' (WP413b, p.1966)

6. WHAT OPTIONS EXIST IN FULFILLING THE WCB’S REHABILITATION MANDATE MORE EFFECTIVELY AND MORE EFFICIENTLY? WHAT ARE THEIR BENEFITS AND DISADVANTAGES? WHAT ARE THEIR LIKELY COSTS?

6.1 The research team found little documentation of analysis of alternatives. One example was presented in the 1994-1999 Strategic Plan for the Rehabilitation Centre:

- Incentives to employers (to provide rehabilitation at the worksite, to take workers back) may assist in promoting work return. Disincentives to workers should be removed.
- Legislation about "right to rehabilitation" and requiring employers to provide jobs for returning workers may or may not be helpful in the province.
- External providers could set up and offer any type of program for which the WCB was willing to pay. We need not think of the Rehabilitation Centre as a niche provider.
- A single point of contact and accountability concerning the rehabilitation of an individual is needed.
- Closer or earlier links with employers are needed.
- More rehabilitation and assessment should occur at the worksite.
- Better communication is needed regarding the Rehabilitation Centre's role.
- We need to continue to provide both evaluation and rehabilitation.
- We should use existing standards for external providers.
- We should consider an ombudsperson for the Rehabilitation Centre.

There were opposing views on:

- Using Rehabilitation Centre facilities to serve non-WCB customers.
- The degree to which the WCB should assist workers in overcoming noncompensable problems interfering with return to work
- The Rehabilitation Centre's primary client
- Whether or not to serve workers with the most complex problems
- The degree to which the Rehabilitation Centre should be involved in brokering, innovation, standard setting and monitoring. (WP159, pp.10-11)

In the examples found, the focus is primarily inward looking. Options relating to improvements within the current model are presented in Section 2.2.6 of Part 1 of this report and are not repeated here.
With respect to the larger picture and overarching options, some senior WCB representatives were asked during interviews whether they had examined alternative models to the current WCB structure in British Columbia. None of them had. Nor had they been asked to.

6.2 Structural Options

There are various work-injury models in use around the world. Some are described in issue 4 above. All have their own set of benefits and disadvantages. There are also prerequisites that will permit a certain structure to work or enhance it. These include historical factors, cultural attitudes, political will and the overarching legislative framework.

Major structural change such as the dismantling of the WCB and other organizations and bringing them together under one organization, or dismantling the WCB and having work injury administered as part of the social insurance network generally, are beyond the scope of this paper. They belong under the discussion of governance since they have implications far wider than rehabilitation and return to work.

6.3 Delivery options

There are other options to the delivery of rehabilitation services that could be considered:

6.3.1 *Combine all rehabilitation activities of all provincial government agencies in BC under one roof and create a separate organization for this purpose*

WCB, ICBC and departments in the provincial government are the major government agencies in BC providing rehabilitation to clients.

Benefits might include:

- opportunities for further specialization among staff, and thus
- improved services for clients; and
- potential cost savings (although bigger is not always cheaper or better).

Problems/disadvantages might include:

- eligibility criteria differ among the providers, which may present barriers;
- different delivery modes are employed: for example, the WCB primarily uses in-house staff, whereas ICBC depends far more on external providers and is not likely to change given the legal aspect of tort cases;
- current services levels differ; this could mean that all services would either have to be brought up to one level, which has cost implications, or reduced to a common level, which is likely not acceptable politically;
- possibly reduced services for some clients;
• possible ‘alienation’ of clients if the organization were to become too big; and
• each agency would still need some in-house staff to make eligibility
determinations and liaise with the rehabilitation provider; thus some internal costs
would remain.

It is not known how much legislation would require amendment, as this approach would
not affect eligibility but delivery mode. It would, however, likely require a lot of
marketing at the political and administrative levels to make this option acceptable and
viable.

Such an organization may also presuppose a large central facility, which is contrary to the
current trend of providing services ‘closer to home’. On the other hand, one large
organization might be able to provide a number of smaller facilities spread around the
province, which might prove politically more acceptable.

6.3.2 Combine selected rehabilitation activities of all provincial government agencies under
one roof

Not all agencies provide the same rehabilitation services. To avoid problems that could
occur through offering some services such as business start up assistance to WCB clients,
but not to clients of other agencies, it might be possible to limit the activities that are
offered through a collective agency. These might include some vocational rehabilitation
services such as job search, some medical services and some psychological counselling.

The benefits and problems/disadvantages are essentially the same as described above, but
on a different scale. It could result in more bureaucracy as existing agencies would still
need in-house staff to provide those services not provided by the one-roof agency. The
major disbenefit at the client level is that clients would likely have one more organization
to contend with. From surveys we know that WCB clients are already unhappy with the
number of different contacts they have to make.

6.3.3 Partnerships regarding specific activities

There are opportunities to develop partnerships among all or several agencies that could
benefit those agencies and their clients. Partnerships could be developed to deal with
specific issues or specific types of services. They could involve delivery aspects or
research to improve delivery.

Benefits might include:

• a partnership could provide an unsurpassed medium for sharing information and
ideas provided the partnership is open and members are committed and trusting;
• there could be a synergy where the sum is greater than the parts; partnerships can
provide a learning experience and a source of best practices by looking at
common problems to see how different agencies have attempted to resolve them.
Problems/disadvantages might include:

- partnerships are expensive and time consuming; they take time to establish and time to nurture
- each partner has to have and maintain an interest in the partnership i.e. there has to be some value added and this may be difficult to achieve given that different agencies are working with different agendas over different time scales

6.3.4 *Agencies maintain separate service delivery but pool funding and share results for specific areas*

To the extent that agencies providing rehabilitation have the same general knowledge and information needs, cost savings and improved or increased results might accrue from a joint approach to specific areas such as research, labour market analysis, and staff training. The disbenefits listed for partnerships would likely apply here. A joint mechanism to administer the shared funding would be required.

6.3.5 *WCB maintains its independent services but increases the involvement of the private sector in delivery*

To a large extent this is already happening with increased reliance on third party providers.

6.3.6 *Full privatization of WCB’s rehabilitation services*

There are models in the US where responsibility for delivering rehabilitation services has been fully privatized. The Workers’ Compensation Board role is reduced to determining eligibility and monitoring quality and outcomes.

For the WCB of BC there are implications if such a route were to be pursued. These include staff issues and contract negotiations with the bargaining units, and the future of the Rehabilitation Centre.

6.3.7 *Alternatives to rehabilitation services*

There are models where the emphasis with respect to vocational rehabilitation has been away from direct delivery of services to providing incentives for employers to hire injured workers.

With respect to Social Security Disability Insurance in the US, members of the Congress and advocates for people with disabilities have proposed various reforms, including tax incentives to help improve return to work outcomes. These reforms include changes that would allow beneficiaries who work while on the rolls to keep more of their earnings, safeguard medical coverage, and enhance vocational rehabilitation. (WP299, p.1)
6.4 Duty to accommodate

Duty to accommodate is an evolving concept. Many front line staff support making it stronger in BC or even incorporating it in legislation.

In BC, duty to accommodate is not reflected in the language of any statute standing alone. However, the Supreme Court of Canada has construed antidiscrimination language in Human Rights legislation (including the Canadian Human Rights Act and the British Columbia Human Rights Act) as including a duty to accommodate. (WP431, p5)

In determining whether an employee or potential employee has been discriminated against within the meaning of Human Rights legislation, courts will look at whether the employer and/or union met the duty to accommodate the employee. The BC Human Rights Act and the Canadian Human Rights Act protect employees from discrimination with respect to employment on enumerated grounds. The enumerated ground which is likely to arise in the workers’ compensation context is physical disability.

The term ‘disability’ is not defined in the BC Human Rights Act or in the Canadian Human Rights Act. However, it is broadly defined in the case law.

The Supreme Court of Canada has established that two types of discrimination are possible: direct discrimination and adverse effect discrimination.

In direct discrimination, a discriminatory rule or practice will be struck down as a violation of the Human Rights Act unless it constitutes a bona fide occupation requirement (BFOR). A rule or practice will not qualify as a BFOR unless it can be demonstrated to be reasonably necessary for economic and safety reasons. If the discriminatory rule or practice is indirect (adverse effect discrimination), then, even where the rule is a BFOR of the job, the employer has a duty to accommodate those affected by the rule up to the point of undue hardship. The employer has the burden of proof in showing efforts to accommodate up to the point of undue hardship.

The Supreme Court of Canada has also held that unions have a duty to accommodate employees. A union must assist an employer in accommodating an employee up to the point where such accommodation would cause undue hardship on other employees.

There is no specific rule of general application to determine whether an accommodation measure is ‘reasonable’ or ‘up to the point of undue hardship’; it is determined on a case by case basis. This makes generalizations from decided cases difficult. However, the courts have provided some guidelines, including:

- individual testing;
- modifying work schedules;
- modifying job duties;
- tolerating absences; and
• providing or modifying equipment or devices.

Employees have a duty to assist their employers and unions in the search for reasonable accommodation.

Duty to accommodate is encoded into provincial human rights legislation in Ontario, Manitoba and Yukon Territory; in other provinces it is considered implicit in provincial human rights legislation. It is also found in some workers’ compensation legislation.

In Ontario, the legislature has expressly incorporated a duty to accommodate to the point of undue hardship in the definition of the BFOQ (bona fide occupational qualification) defence (Section 11(2) of the Ontario Code). The Code incorporates the duty to accommodate in the test for a BFOR and restricts the factors which may be considered as relevant to the determination of undue hardship to costs, and health and safety requirements. Costs must be quantifiable, related to the accommodation and must be so substantial that they would alter the essential nature or affect the viability of the enterprise in order to amount to undue hardship. Health and safety risks must be shown to be bona fide and the employer must be shown to have attempted to minimize health and safety protection through alternative means which are consistent with the accommodation required. Objective evidence is required to show costs for health and safety risks amount to undue hardship.

Recent amendments to the Ontario Workers’ Compensation Act (s.54) provide a strong obligation that an employer provide alternative work to a disabled employee. Under this scheme, the WCB decides whether a worker who has suffered a compensable injury is able to perform the essential duties of his/he pre-injury job or some other suitable work. The Board notifies the employer who must then reinstate the injured worker. The re-employment obligation lasts until the earliest of two years after the injury, one year after the Board notifies the employer that the worker is able to perform the essential duties of the pre-injury job, or until the worker turns 65. If necessary, the employer must accommodate the work or the workplace to the needs of the worker. Limitations on this duty to accommodate are encoded in the legislation. An employer need only re-employ an employee who had worked for it continuously for at least one year before the injury. Employers with less than 20 employees have no obligation at all to re-employ injured employees. Employers in the construction industry are subject to special re-employment obligations prescribed by regulation.

In Quebec, S.32-39 of the Occupational Health and Safety Act provide a right of protective reassignment in cases where a worker’s health is endangered by exposure to contaminants. The re-assignment lasts until the condition of the worker’s health allows him or her to resume former duties. S.40-48 provide the right of reassignment for a pregnant or breast feeding worker away from employment which is hazardous to herself or the foetus or child. Failing reassignment, the worker may obtain compensation during leave.
In BC, the Workers’ Compensation Act does not directly encode a duty to accommodate, but S 16(1) of the Act provides the Board with an ability to encourage accommodation measures. It does not allow the Board to force any requirements upon employers.

Some of the Board’s current policies require the Board to encourage employer accommodation measures and allow the Board to provide financial assistance at its discretion. For example, policy 86.10, which sets out guidelines as to when rehabilitation assistance will be provided by the Board, and 87.00 which sets out the principles for assisting a worker to return to employment. 87.10: ‘if the worker cannot return to the same job, the employer will be encouraged to accommodate job modification or alternate in-service placement.’ Policy 88.22 provides that the Board may provide financial assistance for the modification of jobs and work sites, including expenditures for special equipment and/or tools, if appropriate and necessary in facilitating the worker’s return to employment.

In its submission to the commission (WP446, p.36), the CEU noted that individual vocational rehabilitation consultants (VRCs) are not in a position to enforce duty to accommodate legislation, nor can they act as workers’ advocates even if it appears employers are in violation of workers’ human rights. VRCs can provide information about duty to accommodate — but that is all. It is the responsibility of the workers to decide if they will file a grievance or go to the BC Council of Human Rights. This process takes months to years to complete. The CEU concludes: ‘At present, the Board has no specific authority to require an employer to provide reasonable accommodation to an injured worker’.

The Roeher Institute (WP432) notes that if duty to accommodate is not legislated, cases are all too easily dismissed and the objectivity tests of BFOR/BFOQ’s are not always met. The public, employers, and people with disabilities generally have little awareness of the duty to accommodate even where such a duty exists. Making it part of law and developing accompanying guidelines heighten awareness.

At the same time, there are many issues to be considered before incorporating duty to accommodate in legislation.

Employers and unions are rarely required to accommodate individuals who need on-the-job attendants for medical or personal care. The cost of such support is likely to be considered undue hardship. However, cases that require adapting the workplace to employees’ physical limitations are more likely to be considered reasonable. As a result, the duty to accommodate is inequitably applied, depending on the type of disability and on the accommodations required.

Systemic discrimination occurs during the hiring stage because people usually go through the hiring process unaccommodated. Currently many applicants choose not to disclose hidden disabilities during job interviews, fearful that employers will either not hire them or fire them rather than make accommodations.
When imposed at all, the duty to accommodate has been imposed solely on employers. ‘This imposition erroneously assumes that employers are principally responsible for the barriers to employment ... They can hardly be brought to account for the generations of employment practices and technologies developed through government regulation and support that pose serious obstacles for people with disabilities. Nor can they be held accountable for barriers outside the workplace, such as the lack of training and education... Employers bear some responsibility for removing barriers to employment; however, it seems reasonable that society-at-large must assume part of that responsibility.’

BFOR/BFOQ’s may entrench narrow ways of thinking about work and about how people with disabilities can perform job tasks; they can also be used to blame the victim and let society off the hook because they do not impose a responsibility on society to ensure people’s access to the opportunities needed to satisfy BFOR/BFOQ requirements.

Nor is there a shared responsibility between society, employers and unions for making accommodations, which makes it all too probable that employers’ claims of undue hardship will go unchallenged.
APPENDIX 1

Accountability Framework

The joint Auditor General and Deputy Ministers’ Council report *Enhancing Accountability for Performance: A framework and implementation plan* (the ‘Accountability Framework’) calls for increasing accountability. It examines:

- what government should be accountable for;
- who should be accountable for government performance;
- how government should be accountable for its performance; and
- how the information could be used.

While this document is directed towards ministries, the principles it contains incorporate the concepts of sound and open management that can be applied equally well to other government organizations. Through this research project, they have been applied to the WCB.

With respect to the WCB and its stakeholders, increased accountability would:

- help stakeholders assess the impact that the Board has on their lives and what has been achieved with funds raised by the Board;
- tell Board managers how they are doing — where they are succeeding and where they are not;
- influence the way programs are managed through improved public awareness;
- ensure that stakeholders and the public in general receive fair reporting about the Board’s performance;
- ensure that Board managers are held accountable for performance; and process or input controls do not unnecessarily impede performance;
- ensure that the Board consistently conducts its business in a fair, legal and ethical manner, and the public knows it;
- ensure that stakeholders and the public in general are aware of the standards of service they can expect; and
- ensure that stakeholders and the public in general have confidence that the Board works and that it operates in the best interests of its stakeholders.

The authors of the Accountability Framework anticipated that full implementation would take five years in government departments. The framework, which was established in April 1996, was two-fifths the way through the anticipated implementation phase by the spring 1998, when the data gathering and analysis for this report were conducted. While it was not anticipated that all parts of the framework would be operational by 1998, there should be some significant movement towards implementation.
APPENDIX 2

Canadian Comprehensive Audit Foundation
Effectiveness Attributes

In 1987, the Canadian Comprehensive Audit Foundation issued twelve attributes of effectiveness which can be summarized as follows:

1. **Relevance**: the extent to which a program makes sense in light of the problems or conditions to which it is intended to respond.

2. ** Appropriateness**: the extent to which the design of a program or its major components, and the level of effort being made are logical, given the specific objectives to be achieved.

3. **Achievement of intended results**: the extent to which goals and objectives have been realized; this involves not simply reporting what has happened as a result of an activity or program but reporting in such a way that helps determine whether the level of achievement is satisfactory.

4. **Acceptance**: the extent to which constituencies to whom a program is directed judge it to be satisfactory.

5. **Secondary impacts**: the extent to which other significant consequences, either intended or unintended and either positive or negative, have occurred.

6. **Costs and productivity**: the relationship of costs, inputs and outputs.

7. **Responsiveness**: how well an organization is positioned to adapt to changes in such factors as markets, competition, available funding or technology

8. **Financial results**: the accounting for revenues and costs as well as the accounting for and valuation of assets, liabilities and equity.

9. **Management direction**: the extent to which the objectives of an organization, and its component programs or lines of business are clear, well integrated and understood, and appropriately reflected in the organization’s plans, structure, delegations of authority and decision-making processes.

10. **Working environment**: the extent to which the organization provides an appropriate work atmosphere for its employees, provides appropriate opportunities for development and achievement, and promotes commitment, initiative and safety.
11. **Protection of assets**: the extent to which important assets (for example, key personnel, sources of supply, valuable property, agreements, important information) are safeguarded so that the organization is protected from the danger of losses that could threaten its success, credibility, continuity and perhaps its very existence.

12. **Monitoring and reporting**: the extent to which key matters pertaining to performance and organizational strength are identified, carefully monitored and reported; the results of that monitoring should be reported regularly and accurately. The emphasis is on monitoring and reporting key items that are crucial for accountability, for success or failure — not everything.
APPENDIX 3

Persons Interviewed

WCB:
Ron Buchhorn  Vice President, Rehabilitation and Compensation Services Division
Julie Wakelin  Director, Vocational Rehabilitation Services
David Blair  Director, Medical Services
Izabela Schultz  Director, Psychology
Linc Johnson  Co-Director, Rehabilitation Centre
Greg Feehan  Co-Director, Rehabilitation Centre
Roger Piper  Controller, Rehabilitation and Compensation Services Division
James Fraser  Manager, Finance and Administration, RCSD
Susan Pandak  Vocational Rehabilitation Consultant
Chris Hartman  Manager, Vocational Rehabilitation Services
Margot Forman  Manager, PERU
Mario Villa  Manager, Controller’s Office

Two group sessions were held:
Psychology staff attended by 10 persons
VRS staff attended by 26 persons

Subsequently, a few individuals from the group sessions contacted the research team to provide additional information

Non-WCB:
Selected organizations were contacted to provide information on their rehabilitation processes, for comparative purposes. These included:
Gary Goodwin  Coordinator, Partnership Development, Human Resources Development Canada (HRDC)
Joan Johnson  Senior Program Officer, Canada Pension Plan, HRDC
Annette Crocker  Manager of Disability Claims, Manulife Financial
Diane Sjodin  Manulife Financial
Anita Gill  Manager, Rehabilitation Technical Services, ICBC

Others:
Dr. David Hunt
APPENDIX 4

Detailed Research Findings And Evidence By Hypothesis:
Vocational Rehabilitation Department

HYPOTHESIS 1 THE DIVISION'S MANDATE IS RELEVANT AND THE DIVISION KNOWS WHAT IT IS SUPPOSED TO BE DOING

CCAF attributes: 1, 2 (in part)

Evaluation criteria

1.1 purpose (mandate, mission, goals/objectives) are clearly stated
1.2 the program makes sense in light of the conditions to which it is intended to respond
1.3 measurable, outcome-focused targets have been established for long-term goals/objectives
1.4 there is a logical, plausible link between mandate and goals/objectives
1.5 goals/objectives reflect/are cognizant of the challenges the Division faces

Conclusions

Hypothesis 1 is supported by the evidence available to the researchers.

The mandate, mission and objectives for the Vocational Rehabilitation Services Department are well documented. The program appears generally adequate to respond to the prevailing challenges. There may be some groups who are not receiving the attention they need or who could benefit from additional services. Such groups include clients with ASTD’s. Public accountability could be improved if there were more quantified targets and if the bases against which long term objectives are to be measured were clarified.

The linkages between mandate, objectives, activities and outcomes, which were tested during the 1994 Evaluation of Workers with Back Injuries, still appear plausible.

The Department’s management attempts to remain informed regarding both internal and external challenges and to build those challenges into business plans.

Vocational rehabilitation staff have identified some issues that require answers. They also commented on the lack of duty to accommodate legislation, which they feel would provide very positive support to their attempts to return workers to the injury employer. VRCs are also concerned about the negative impact some appeal decisions have on their work.
Research Findings and Evidence

1.1 Pursuant to section 16 of the *Workers’ Compensation Act* (see section 2.1 above), provision of vocational rehabilitation services is discretionary. Thus, within the provisions of the Act, it is at the discretion of the Board to decide what vocational rehabilitation services to provide, and to determine who shall receive services and which services they shall receive.

1.2 In its October 1997 report, the Royal Commission recommended that the discretionary nature of responsibilities towards surviving spouses and dependents be made mandatory:

1.3 VRCs also assist in the assessment of employability for permanent disability and for temporary partial disability under s.23(3) and 30(1) respectively of the Workers’ Compensation Act.

A recent change was made to ensure that Code R - Income Continuity payments comply with the legislation.

1.4 The scope of vocational rehabilitation coverage has increased over time and now includes not only claimants with ‘traditional’ types of injuries such as amputations, but also those with psycho-social problems and occupational health diseases. Preventive rehabilitation may also be provided for claimants, including those with Activity-related Soft Tissue Disorder (ASTD) (repetitive strain), provided they meet the appropriate referral criteria.

1.5 The Panel of Administrators has recently reinforced the importance it attaches to vocational rehabilitation. The 1996 mission statement reads:

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.

In the 1996 strategic plan, the Panel made ‘to assist in returning injured workers to work through medical care and vocational and clinical rehabilitation’ the second most important objective of the board after prevention. This status is confirmed in the 1998 business plan, which notes:

After prevention, the rehabilitation and return to work of injured workers is the priority for the Board.

1.6 The VRS Department’s 1998 business plan notes its mission statement:

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

1.7 These documents clarify the debate that existed regarding employment and employability. That debate was at its height when there was no VRS Department and
thus no clinical oversight. According to all the documents reviewed and those interviewed, ‘return to work’ is now the objective. The strategic plan states clearly that:

... providing safe, timely and durable return to pre-accident employment will always be a primary objective of board operations.

1.8 ‘Quality rehabilitation’ is the stated intent of the Board. It was the second element in the board’s mission statement developed under the previous regime. The Senior Executive strategy meeting held in early 1995 set as a priority for the year:

The quality and outcomes of the physical, psychological and vocational rehabilitation of workers will meet or exceed international standards for professional rehabilitation and cost effectiveness.

The research has not been able to identify international standards or benchmarks. The Director, VRS is also not aware of any. It is not known what standards the above statement refers to.

1.9 Quality rehabilitation is defined in the manual as:

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

1.10 In the 1995 corporate business plan, rehabilitation services to injured workers was the third of six primary business services and products identified.

1.11 In 1992, the VRS Department undertook a strategic analysis for planning purposes. The introduction to the resulting document notes that VRS ‘has been given priority by the Board of Governors ...’ The document sets out VRS’ primary objective: ‘To facilitate workers’ return to work through the provision of quality rehabilitation.’

1.12 The manual presents three objectives for vocational rehabilitation:

- To assist workers in their efforts to return to their pre-injury employment or to an occupational category comparable in terms of earning capacity to the pre-injury occupation.

- To provide the assistance considered reasonably necessary to overcome the immediate and long-term vocational impact of the compensable injury, occupational disease or fatality.

- To provide reassurance, encouragement and counselling to help the worker maintain a positive outlook and remain motivated toward future economic and social capability.
The board develops its vocational rehabilitation objectives in light of an analysis of both key issues and trends, for example, the internal and external scans prepared prior to development of the 1996 strategic plan and the VRS Department’s strategic analysis in 1992.

The Director, VRS noted that the template used to develop departmental business plans requires a review of both internal and external factors. She considers external factors to include the economy and business environment as well as political, technological, social and community changes. Internal factors include strategic initiatives and the progress msfr in implementing them, human resources, business tools and information requirements. She reports under these headings in the business plan. There is no formalized mechanism to collect such data. Information comes from a variety of sources including VRCs and managers, other WCB staff and external contacts.

The 1996 strategic plan summarized some of the major issues:

Safe and timely RTW also poses a challenge. The human costs of prolonged absence include deconditioning, reduced likelihood of recovery, increased pressure on family and personal relationships and a loss of self-esteem. The financial costs are also high with the direct costs of wage loss, health care, vocational rehabilitation, re-training, lost production and disrupted workflow at the work site.


The 1992 strategic analysis recognized the need to ‘enlist the participation of employers, labour and the community in developing a cooperative strategy for the delivery of quality rehabilitation’.

The 1996 strategic plan was circulated to different stakeholders prior to finalization in an attempt to gather and synthesize the (inherent) conflicts relative to the different stakeholders, particularly workers and employers and their organizations, but also others such as government and the general public.

The board’s determination of what vocational rehabilitation is and how this goal is to be met is set out in the Rehabilitation Services and Claims Manual (RSCM). Chapter 11:

- cites the legislation,
- presents the board’s definition of ‘Quality Rehabilitation’,
- presents seven guiding principles of quality vocational rehabilitation,
- presents the objectives of Vocational Rehabilitation Services,
- defines the services that may be provided,
- sets out the departmental mandate, and
• sets out details regarding eligibility and referral criteria.

This Chapter was revised in 1992 to respond to the ‘lack of clearly defined departmental goals’ which had resulted in ‘widely discrepant interpretation and application of policies’. The current statements are clear.

1.17 The method of setting and amending policy appears to be: line staff develop the proposals which are then forwarded to the Panel of Administrators (or their predecessor the Board of Governors) for approval. Once approved, a replacement page is distributed to holders of the manual for them to substitute. A quick check of randomly selected items showed that this process is generally followed. With respect to the elimination of the manager’s review, the manual has not been amended. In an interview, the Director, VRS indicated that she and her managers continue to conduct manager’s reviews. She considered the elimination to apply to claims reviews, rather than vocational rehabilitation reviews.

1.18 In 1994, the board produced the Vocational Rehabilitation Services Procedure Handbook. It serves as a ‘reference guide for VRCs’ and outlines the ‘procedural requirements of the VRS, Compensation Services Division’. Since 1994 there has been only one major revision, in September 1996 concerning the change to Code R practice. A further update is scheduled for later this year.

This document sets out very clearly such items as policy references, purpose, process and procedure. It distinguishes between what must be done and what may be done.

1.19 Despite these clear statements in the manual and handbook, because vocational rehabilitation services are discretionary, interviewees stated that a lot is left to common sense and practice is not always consistent. Some thorny issues that continue to perplex people include:

• Can a worker be ‘forced’ to relocate for employment purposes?
• How much job search allowance should an individual receive? Although the Department uses Statistics Canada guidelines for job search allowance, they too are open to interpretation.
• Should VRCs follow up with clients after they have returned to work? The documents are silent on this issue. While some feel it is inherent in the concept of quality rehabilitation, practice varies between consultants.

1.20 In an interview, the Director, VRD noted that vocational rehabilitation services are generally provided to claimants likely to have a permanent impairment. While this is generally considered to be the group most in need, it does exclude many persons with ASTD’s who may be eligible for preventive, but not for other vocational rehabilitation services. It may be that early vocational rehabilitation intervention with some of these claimants would have long term benefits: as it is, these claimants receive treatment and then return to the same work that caused the problem in the first instance. Another group that may not receive the appropriate level of benefits are high wage earners who face a lot
of barriers. It appears the WCB could be smarter with certain populations of injured workers.

1.21 The research has identified only two quantified outcomes for vocational rehabilitation.

- The 1996 strategic plan includes the target ‘to improve the safe RTW rate for workers with permanent disabilities by 10% by 2000’. According to the Board, ‘This performance measurement is based on the number of closures resulting in a RTW outcome divided by the total number of vocational rehabilitation closures for the given period.’

- The 1998 corporate business plan includes the client service objective ‘to improve the time from disablement to safe rtw by 20% by 2000’. According to the Board, this is ‘currently measured using retrospective duration, which reports the average number of wage loss days paid on a claim from first payment to first closure of the claim.’

The Director, VRD had been unable to identify the base against which the improvement will be calculated. VRC’s who attended the group interview also noted that they are unaware of and concerned about this base. This has an impact on the reliability of figures presented, which has implications for public accountability. It also brings into question whether the targeted percentage improvements are appropriate.

Neither of these targets is cited in the VRS Department’s 1998 business plan.

1.22 Our analysis suggests that there is a logical, plausible link between mandate and goals and objectives. They also appear to be in line with the general approach taken by many other organizations with similar responsibilities. (For further discussion, see Part 2, Issue 4 of this report.) The linkages today are similar to those examined in the 1994 evaluation of back injured workers; the evaluation did not report any concerns regarding the internal logic of the program.

1.23 Apart from Human Rights legislation, there is no duty to accommodate, that is, no requirement on the part of employers to accommodate injured workers. As Chairman of the Board of Governors, J. Dorsey commissioned the Board’s Legal Services to draft a paper on this subject. The VRCs at the group interview noted that this paper made valid points regarding the VRS Department. VRCs generally feel that a duty to accommodate requirement would assist them in their work and would allow them to promote return to work with the injury employer. The status of this paper and the Board’s position on this issue is unknown.

1.24 At the group interview, the VRCs also commented on decisions made regarding appeals. In their opinion, there is inconsistency in the decisions of the Workers’ Compensation Review Board that profoundly affect the role of the VRC. They noted VRCs have no opportunity to verify or refute what a worker presents through an appeal. Some decisions
are considered arbitrary and can destroy the trust that is required in the VRC/worker relationship.

VRCs also noted what they consider to be an all too common occurrence, namely the situation where an appeal is denied but the Board should consider vocational rehabilitation assistance. In the VRCs’ opinion, vocational rehabilitation is offered as a carrot to the worker, but the VRCs do not know how to respond. The manual and handbook do not provide guidance on such issues.
HYPOTHESIS 2  THE DIVISION HAS ESTABLISHED A STRATEGY TO ACHIEVE ITS OBJECTIVES

CCAF attribute:  2 (in part)

Evaluation criteria:

2.1  intended performance is clearly established through effective planning processes
2.2  planning at the Division level is done in the context of the entire WCB; i.e. there is a comprehensive system of strategic direction
2.3  management processes are integrated and consistently focused on key aspects of performance
2.4  the focus at all levels is on intended and actual performance
2.5  objectives and plans are tailored to meet the mandate within resource allocations
2.6  adequate funds and staffing are dedicated to the process to ensure success
2.7  the plans clearly communicate the standards of service clients (workers, employers) should expect when accessing rehabilitation programs
2.8  the design of the program and its major components, and the level of effort being made, are logical, given the objectives to be achieved

Conclusions

Hypothesis 2 is generally supported by the evidence.

Within the Board, the VRS Department has been a leader in the area of planning. The strategies presented and currently being pursued by the Board appear to support the objective of return to work. They generally meet the evaluation criteria. They note the need to be outcomes oriented and planning documents do present some performance indicators.

There is evidence that planning within the VRS Department takes into account what is happening elsewhere in the Board. Indeed, given the matrix management system in place, the Department is forced to recognize processes and initiatives in the Service Delivery Locations and the Rehabilitation Centre.

Staffing appears to be adequate to meet objectives: in recent years, staffing levels have remained more or less static while accepted referrals have declined. There is no limit set for expenditures required to meet the vocational rehabilitation needs of clients. The Board spends what its professional staff consider necessary to meet the needs of individual clients. Without a cost-benefit analysis, we cannot determine whether adequate funds and staffing are dedicated to the process (criterion 2.6) nor whether the level of effort is logical (criterion 2.8).

Overall, the design of the program and the level of effort being made appear logical relative to the objectives.
Research Findings and Evidence

2.1 As far as we can determine, the board’s first corporate business plan was produced in 1995 and the first strategic plan for the board as a whole appeared the following year. However, the VRS Department developed its own strategic analysis for planning purposes as early as 1992.

2.2 The 1995 corporate business plan presents a strategy to attain the rehabilitation priority. Under the strategy all rehabilitation activities are to be outcome oriented. External bench-marking is to become a regular part of the business; post-discharge and in-treatment surveys will be conducted; and selected rehabilitation services, both inside and outside of the WCB will be subjected to complete cost/benefit analysis.

2.3 In developing the 1996 WCB strategic plan, the board determined that outcome-oriented vocational and clinical rehabilitation were critical factors.

RTW strategies are an essential mandate of the board. Workers, employers, unions, business associations and others also play an important part. Increasing the rtw outcomes is a win/win situation for both employers and workers. We also recognize that rtw requires a commitment from employers and workers which starts at the worksite. We are developing even more effective ways to support this process.

Strategy 3 of the plan notes a main focal point: ‘transform service to injured workers through improved claims processes and expeditious, safe and durable rtw’

The strategy also states that ‘The board has a clear duty to provide timely, professional, efficient service.’ The WCB is a monopoly and a regulator; as such it must ‘serve its stakeholders and the public interest in a sensitive, respectful and effective manner.’

Business principles presented in the plan include: results focused, service driven, cost effective, and prudent.

Related client service objectives include:

- raise client service satisfaction to 85% by 1998, and
- improve the safe rtw rate for workers with permanent disabilities by 10% by 2000.

According to the Board, ‘It is anticipated that both these measures will continue to be used as a basis for tracking improvement in these areas. With the introduction of e-file and Case Management, additional measurements will be built into the system. This will include capture and analysis of all closures that occur throughout the claims management cycle, including closures of new claims as well as reopened claims. With this information we will be able to determine the average number of days a claim was open and received timeliness payments by claim type as well as measure the RTW outcomes.'
This information will be used as an additional return to work indicator along side the two measurements currently used.’

One of the financial objectives is: ‘Achieve and maintain our published standard of fiscal responsibility’; this includes raising administrative cost efficiency by 20% by 2000.

The community profile objective is: ‘To earn the respect of our community’; this includes ‘providing communications support to maximize effectiveness of ... rtw initiatives’ and ‘championing the accommodation of persons with disabilities in the workplace’. This latter is an integral part of VRC’s work with employers.

Comments regarding injured worker service delivery note that through case management, a worker/survivor or dependent will have a single point of contact, a strategy that is aimed at removing handoffs from one staff person to another, which has been a major irritation in the past.

Another strategy, disability management, has a rtw focus:

The concept of disability management is focused on workers, employers, unions and other disability insurance providers working with us to achieve RTW and to prevent recurrence of injury in the workplace. Effective workplace integration will minimize the use of simulated work hardening programs and focus on returning the workers to their workplaces for GRTW ...

Specific strategies will be required for small and medium-sized business in this regard who do not have the capacity or capability that large firms have to support disability management. The board will work with industry associations, community organizations and other agencies to see if some programs can be tailored for small business.

2.4 The 1998 corporate business plan expresses generally the same objectives, strategies and outcomes/performance measures as the 1996 strategic plan. A new client service objective is:

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

Under strategy 1: client service, an activity is: initiate a monthly survey process and ‘Tell Us What You Think’ comment cards to measure client satisfaction with current practices and new strategies, as well as to identify areas for potential improvement. The comment cards are being completed by claimants. They are colour-coded so that those completed by VRS clients are readily identifiable. The Department is in the process of approving additional questions directed specifically towards vocational rehabilitation.

2.5 Strategic planning within the VRS Department can be traced back at least to 1992. The Department’s ‘strategic analysis for planning purposes’, which was developed with input from managers, sets out the board’s mission and links the VRS objectives to it. It
prioritizes the VRS objectives, sets out specific activities and time frames to implement those objectives, and identifies outcome measures.

2.6 The 1997 RCSD business plan is generally in accordance with the corporate level plans in terms of thrusts. This is the first planning document identified through the research that makes a specific reference to preventative rehabilitation.

There are few new initiatives that focus directly on vocational rehabilitation, although it is involved in several of the others such as e-file and case management. One specific vocational rehabilitation initiative is to revise the vocational rehabilitation handbook and make it available on-line in support of the e-file initiative. The 1994 version is now on-line.

2.7 The 1998 RCSD business plan (draft) is similar to the 1997 business plan. New items include:

- reporting return to work as a percentage of closures with rtw as expected outcome;
- evaluation of vocational rehabilitation intervention programs to ensure efficiency and effectiveness:
  - formal training and small business start-ups,
  - training on-the-job and others; and
- conduct of a pilot on the job club preferred provider network.

2.8 The business plans estimate resources for the Department as a whole. Staffing levels are allocated and have remained fairly constant in recent years while the number of accepted referrals has declined. (See Hypothesis 5 for further discussion.)

There is no limit set on what the Department may spend to meet the needs of accepted clients. The Department spends what is required, as determined by the individual VRCs and approved by their managers. It is left to the discretion of staff to determine when ‘enough is enough’.

2.9 The business plans provide data on such items as rtw rates and volumes per VRC desk. As noted in Hypothesis 1, the source of the baseline on which targets for the year 2000 are set is unknown.

2.10 According to interviewees, for the last two to three years, departmental planning has consistently taken into account what is happening within other parts of the Board and is done in the context of the status of implementing the Board’s strategic plan.

2.11 Vocational rehabilitation policy is set out in the Rehabilitation Services and Claims Manual. The VRC Procedures Handbook provides details on specific interventions and procedures to implement strategies. The Department’s plans and strategies appear to be in accordance with the manual and handbook.
HYPOTHESIS 3  THE STRUCTURE OF THE DIVISION IS APPROPRIATE TO ACHIEVE ITS OBJECTIVES

CCAF attribute: 9 (in part)

Evaluation criteria:

3.1 rationale for current structure makes sense
3.2 roles and responsibilities are clear and well-integrated
3.3 lines of accountability are clear: there are clear and unequivocal mandates that assign tasks, confer powers and identify who is responsible for what
3.4 the necessary delegations of authority and decision-making have been made
3.5 these responsibilities etc. are communicated and well-understood

Conclusions

Evidence for hypothesis 3 is mixed.

The rationale for the current structure makes sense to those who have to operate within it. Alternative structures were considered and rejected for practical purposes.

While the roles and responsibilities for VRCs are clear, the lack of job descriptions for the director and senior managers is disconcerting. Until clear definitions of duties are stated, we cannot conclude that criteria 3.2 to 3.4 are fully satisfied. This is particularly true given the complex matrix within which VRS staff operate.

Staff comments in interviews suggest that criterion 3.5 is not fully met and that communications could be improved and made more consistent.

Research Findings and Evidence

3.1 Vocational rehabilitation has always been and remains a part of Compensation Services Division.

On April 27 1996, the President/CEO announced that the VRS Department was to be amalgamated with Medical Services, Psychology and the Rehabilitation Centre in a separate Rehabilitation Division under the same vice president as Compensation Services Division. ‘The purpose in forming two separate Divisions under one Vice-President is to improve worker service by the integration of clinical and vocational rehabilitation into case management practices.’

However, it appears this did not occur. While Medical Services, Psychology and the Rehabilitation Centre were amalgamated into Rehabilitation Division, the Vocational Rehabilitation Services Department remained with Compensation Services Division, where it is now.
Many interviewees who were asked whether the current arrangement is appropriate, answered yes. The Director, VRS commented that clinical rehabilitation staff are mostly concerned with the ‘front end of a claim’, namely the most effective treatment to secure a return to work. In contrast, VRS staff tend to be more involved at the end of a claim, which means it is important to retain a close relationship with other parts of Compensation Services such as Disability Awards.

Some VRS staff would prefer to see Vocational Rehabilitation as a separate division. They feel they are overwhelmed and ‘smothered’ by the sheer volume of claims and that their work is claims driven.

3.2 The current Departmental situation has been arrived at after a great deal of unsettling changes in which the Department was first disbanded and then reformed. There have been eight directors of the Department during the last ten years.

3.3 As of May 1998, the VRS Department comprises one director, four senior managers, three vocational rehabilitation managers, 91 VRCs, about 4 vocational rehabilitation coordinators and support staff.

3.4 For a long period, one or two positions at the manager level remained vacant. To compensate for the backlog of work not done, two additional manager positions were approved by the vice president. All these positions are now filled.

A concern raised by VRCs at the group interview is that there is no VR manager with a professional accreditation in the Interior.

3.5 The Department operates on a matrix basis. The VR managers report to the senior managers, who report directly to the director, who in turn reports to the vice president. The VRC’s also report through the managers to the director for technical/professional purposes. However, for administration purposes, they are located in and report through area offices, service delivery regions or the Rehabilitation Centre. VR coordinators are included in SDL budgets.

3.6 The current organization chart for the Department shows direct and clear lines of responsibility. During interviews with staff, it became apparent that not everyone was always clear regarding who they reported to for what. In part, this situation appears to arise from the complex matrix organization and the level of change. We were advised that the situation is improving as roles become clarified.

However, according to VRCs who attended the group interview, VRS is subservient to and driven by claims. This makes it difficult to plan for staffing. It also suggests to them a lack of concern about their role and a lack of understanding throughout the organization.
3.7 There is no job description for the director position. There is no separate job description for senior managers; they function under the same job description as client service managers. The director is not satisfied with this arrangement and intends to create a separate job description for them.

The VR managers function under the compensation services manager job description. This decision was taken on purpose given the move towards matrix/blended management.

The VRC job description was revised June 30, 1997. Apart from the fact that it does not specifically mention preventative rehabilitation, it appears to cover all the aspects of the VRC position.

The VR coordinators are being phased out with case management, to be replaced by team assistants.

3.8 The specific roles and procedures to be followed by VRCs are set out in the Vocational Rehabilitation Services Procedures Handbook.

3.9 The VRC position description identifies some situations in which VRCs are required to make linkages with external parties including the medical profession, employers, business establishments, unions, and public and private agencies to facilitate the placement of workers and implementation of rehabilitation programs.

3.10 Vocational rehabilitation expenditures on individual cases are left to the discretion of the VRCs and the VR managers. Spending limits/authorities have been established for different levels of staff. The financial signing authority levels are set out in section RPH 090-012 of the VRC handbook. For vocational rehabilitation expenditures, they are:

- up to $10,000 VRC
- up to $40,000 Rehabilitation Manager
- up to $75,000 Director of Compensation Services Division
- up to $100,000 Vocational Rehabilitation Committee
- up to $300,000 Vice President
- over $300,000 President/CEO or two Vice Presidents

For business start ups, section RPH 070-009 states that approval of business start up costs up to $40,000.00 must be approved by the Director, Vocational Rehabilitation Services. Proposals to pay business start up costs ranging from $40,001.00 to $75,000.00 must be reviewed by the Vocational Rehabilitation Committee, which comprises the Director, VRS, the Director or Assistant Director Finance, and a senior delegate of Claims Department. Proposals to pay business start up costs in excess of $75,000.00 must be approved by the Vice President subsequent to a recommendation from the Vocational Rehabilitation Committee.
3.11 All VRCs are aware of the manual and the handbook. However, at the group interview, they commented that there is no consistent way in which they are advised of change. Change notices may be distributed through any or a combination of inter-office memo, e-mail, procedure handbook updates or a manager’s meeting. They feel that different managers may interpret information differently.

3.12 With respect to employability assessments, VRCs are required to work closely with Disability Awards staff. According to VRCs at the group interview, barriers have been erected at the Richmond office which have resulted in undue delays in processing employability assessments. In the Victoria area office, however, this problem does not exist. VRCs question why management is creating barriers, rather than copying the good practices that exist elsewhere.
HYPOTHESIS 4    THE DIVISION PROVIDES AN APPROPRIATE WORK ATMOSPHERE

CCAФ attribute:    10.

Evaluation criteria:

4.1 the Division provides an appropriate work atmosphere for its employees, provides appropriate opportunities for development and achievement, and promotes commitment, initiative and safety

Conclusions

The evidence generally supports hypothesis 4.

Some problems identified in earlier research appear to be resolved. Many agree that morale has improved since 1994-95, and that the work place is more stable.

The Board supports the professional development of all VRCs and is providing financial support to assist individual VRCs further their professional education.

Nevertheless, some staff interviewed believe that there are some issues, some of them long-term, that are outstanding. Many of them centre on how the VRC is perceived by management within the Board. Others relate to the working environment, and the tools to do the job.

Research Findings and Evidence

4.1 The 1995 internal scan stated that ‘Staff morale has been considered low for some time with few surveys to confirm this. Several petitions (mostly from the compensation services area) have raised concerns about workload and other issues affecting morale.’

In part that low morale reflected the lack of stability at the top, which resulted in turbulence, turmoil and turnover, which in turn have diverted the attention of WCB staff from the task at hand. With respect to vocational rehabilitation, the nadir appears to have occurred when the Department was disbanded in 1994-95, which left VRC’s without a professional focus. During the last ten years, the VR Department has had 8 directors, including the Vice President Len McNeely who assumed this responsibility for a while. The current director has served for one year.

4.2 The 1997 Administrative Inventory traces in detail the changes within VRS and concludes that the bleak outlook of the mid 90's has changed for the better. Reasons for this include a renewed focus for VR within its own Department, and the development of clearer guidelines, expectations and standards for the provision of service.
4.3 A major concern has been the prolonged vacancies within the manager level positions. As of May 1998, all these positions were filled and extra managers have been designated to accommodate the backlog.

4.4 Although some union staff (VRC’s) see a move to a management position as ‘selling out’ or ‘crossing the line’, the director has indicated that some staff have expressed interest in management positions and in acquiring experience through acting positions. Staff are encouraged to apply for acting manager positions during the summer months to gain experience.

4.4 Staff turnover appears to have dropped significantly. Over a four to five year period from the late 80’s to early 90's more than 100 VRC’s changed. In the last year, by comparison, there have been only 4 new hirings for permanent positions.

4.5 Workload has been a concern over the years. The Director, VRS noted that the petitions were generated in part in response to workloads and volumes. While the claims adjudicators were the most vocal, the VR coordinator position was created at that time to provide VRC’s with support.

The Administrative Inventories examine trends in workload and activity level indicators but there is no analysis as to the extent to which the complexity, difficulty or scope of that workload has changed.

4.6 Professionalism and the professional status of the VRC position has also been an issue.

The Administrative Inventories are critical of the level of professional and staff development offered and suggest there is a need for the WCB to continually enhance the skills and accountabilities of its front line staff including VRCs. The reports conclude that the WCB will only be able to respond to client needs and the new demands of the changing world of work if their staff have the set of technical, managerial and personal skills to do their job. Once staff have been carefully trained in the goals and objectives of the system, they must be allowed to get the job done, with clear performance expectations and competent supervision.

4.7 The WCB’s training budget as a percentage of total payroll has increased from 1.5% ($1.7m) in 1994 to 4.6% ($6.2m) in 1997; the budget per employee for training has more than doubled from $875 in 1996 to $2,112 in 1997. The Director, VRS, noted that this budget is for training provided by the Board. It covers the training required for initiatives such as case management and e-file. It also covers general training in areas such as conflict resolution.

While the Director was not aware of exactly what percentage of the training budget goes to her department, she saw no reason to suggest that it would be more or less than average across the Board. VRCs at the group interview, however, noted that while they received the same amount of e-file training as adjudicators, they did not receive the same benefit (ten hours paid overtime) the adjudicators received.
The VRCs also noted that the time allowed for training has decreased. The VRC training material developed two years ago envisaged a six-month development period. Now, according to the VRCs, vocational rehabilitation staff have a one-week orientation. There is also no mentoring provided to new VRCs.

4.8 VRCs receive a minimum of four days a year for professional orientation, two in the spring and two in the fall. A professional development workshop is arranged for that time with guest speakers on a variety of subjects relating to vocational rehabilitation. In 1996, the agenda included discussions on ‘Beyond traditional job development’ and ‘Future labour market trends for disabled workers’. Items on the agenda for the May 1998 session include the reporting system used by VRCs, the development of the VR reporting component in e-file, and a presentation on motivational interviewing by a professor from the Psychology Clinic, UBC. An item scheduled for the fall is burn out and stress on the job, which has manifested itself among some VRCs. While attendance is not obligatory, VRCs and managers are expected to attend and most do.

4.9 VRCs are also encouraged to upgrade skills and gain professional certification and may receive financial support, perhaps in the form of having their membership dues paid. Starting this year, the University of Calgary is offering a Masters in Rehabilitation program for students from BC. All VRC’s at the Board were advised of this program and invited to the promotional hearing. The director, 2 managers and 5 VRCs have enrolled. They were self-selected and made the commitment before it was clear whether the Board would provide financial support. Subsequently, the Board has agreed to support all 8 who enrolled. The director will receive 100% reimbursement; the managers will receive all their tuition plus either travel or study leave. Those in the bargaining unit will receive $3,000 per annum (to a total of $6,000) plus educational leave. The normal maximum reimbursement allowed for self-chosen training is $400 per annum. However, this can be increased at the discretion of the Vice-president. We understand that in this situation, the vice presidents of RCS and Human Resources approved the reimbursement levels. In return for financial support, those enrolled are expected to work within the Board for a specific time; should they cease to be a Board employee before that time, they will have to repay some of the financial support, based on a sliding scale.

4.10 Staff are encouraged to participate in the design of many new initiatives. Each of the new initiatives is being piloted and rolled out in phases in order to provide staff with opportunities to provide feedback. Case management is an example.

For this initiative, a survey was conducted with 28 staff in the Prince George: 13 directly involved in the case management prototype, and 15 not directly involved. (A similar baseline study was conducted in the Prince George SDL Feb/97 prior to implementation.) Of the direct participants: 100% felt case management is an improvement over traditional claims management and 90% of these said substantially better or much better.
Other staff were less enthusiastic, but still generally supportive: 66% said better; 33% substantially better; 33% stated no change.

However, for several of the prototype participants, staffing issues have not yet been effectively dealt with. For example, support staff roles were not yet clearly defined, and the full scope of the case manager’s job had not yet been achieved especially with respect to Disability Awards and VR functions: there were still some unresolved aspects in the interface between the VRC and case manager.

Management is seen to lack the flexibility to be creative in solving both the shortage of staff to fill vacancies when case managers are on holidays, and case loads.

4.11 The Administrative Inventories credibly note a need for greater integration within the WCB: all units need to work together in an integrated alliance to rehabilitate injured workers.

4.12 More than one quarter of the VRCs attended a three-hour group interview with the research team. While they agree that some improvements have occurred, many feel that several of the long term problems remain. There is concern over the types of change and the rate of change, and some cannot see the reason for change: there is, they feel, a lot of hype over ‘new’ programs which they feel they have been doing for years. Some are concerned that initiatives such as case management are being implemented without being fully thought through. In their opinion, management is not always supportive and the case of a recent grievance was cited.

4.13 The physical environment within which VRCs work is described elsewhere in this report. One VRC noted that staff in Burnaby SDL have been provided with earplugs, due to the high noise level. The removal of walls in offices has not removed the barriers, as was intended, and has created other problems.

4.14 A concern for VRCs is the potential for contracting out. In the Alberta and Ontario WCB’s, vocational rehabilitation has ceased to exist as a separate department: the function has either been subsumed into case management or outsourced. There are fears among staff that the same will happen in BC, despite what management may say to the contrary. In an attempt to allay this fear, the director has appointed one her managers to clarify the use of external providers and their contracts.

4.15 Another concern is professionalism. Adjudicators may now handle Phases I and II. While this is not new — there have been practice directives for some time — some VRCs see this as a threat because they enjoy this work. Some resent adjudicators doing this work.

Under case management, adjudicators are getting rolled over into case manager positions, whereas VRCs will have to compete for them. Case managers may handle Phases I and II of vocational rehabilitation work, but they may not have the necessary skills or experience, which is only acquired over time. In contrast, the Knowledge, Skills and
Abilities set of VRCs is not considered adequate for the case manager position. Some VRCs see this as diminishing the role and professionalism of the VRC.

4.16 At the group interview, VRCs noted that they do not have all the tools they need to do their job. A specific lack identified is adequate demographic and job-related data.

4.17 In September 1997, an external firm of consultants was contracted to conduct a survey of WCB staff. The overall scores for the Board were consistently brought down by the scores in the Rehabilitation and Compensation Services Division. This includes the scores of VRC staff.
HYPOTHESIS 5  THE DIVISION HAS ESTABLISHED AND IS IMPLEMENTING STRATEGIES TO MEASURE AND REPORT ON THE EXTENT TO WHICH IT IS ACHIEVING ITS OBJECTIVES

CCAF attribute: 3 (in part), 12

Evaluation criteria:

5.1 the Division has identified, monitors and reports regularly and accurately the key items that are crucial for accountability (success/failure)
5.2 performance measurement is appropriate; it must not be too cumbersome, not involve an inappropriate amount of resources nor take too long so that information is not timely
5.3 the indicators used actually measure performance and organizational strength (i.e. they are meaningful)
5.4 performance information is provided on a timely basis so that results can be used in other management processes (planning, budgeting)
5.5 measured outcomes and impacts/findings are used to ensure increasingly limited resources are used in a more/the most relevant, economic and effective manner
5.6 government provides fair, reliable and timely reporting about the intended and actual results for all key aspects of its performance to all interested parties
5.7 reports present data/information and analysis that is accurate, reliable, consistent, complete, meaningful, timely, replicable, impartial and that states assumptions used
5.8 reporting is subject to verification/audit
5.9 performance information is the basis on which decisions are made

Conclusions

Hypothesis 5 is only partially supported by the evidence.

There are several systems in place to collect information and improvements have been made to these systems over time. Nevertheless, the main database for collecting outcome data, the RPM, is temporary and will not be updated; it will be replaced by a system that interfaces with e-file, and this has not yet occurred. There are problems with the RPM, which management is fully aware of. For example, there is inconsistent use of the closure codes by VRCs for data entry and thus concerns regarding the reliability of reporting. Definitions of safe and durable return to work are lacking. The Department does not conduct follow-up interviews with clients after they have returned to work and thus cannot determine the durable element of their objectives. The RPM does not differentiate between new cases and re-openings or re-referrals of previous cases; thus there is a potential for counting more than one return to work for the same individual for one claim. There is also a potential for the Board to double count returns to work for individuals who are seen by VCRs in the Rehabilitation Centre.

The RPM is resource intensive. Data entry is manual and the data files are not readily transferable from VRC desk to VRC desk when a claim file is transferred.
Two key performance indicators are presented for the Department. The bases against which change over time is to be measured is not known.

There is a lack of evaluation of specific vocational rehabilitation interventions to determine their effectiveness. Steps are being taken to address this lack; however, the results are not yet available.

It is not obvious that data are used in planning and decision making.

**Research Findings and Evidence**

5.1. The 1996 strategic plan notes that the Panel of Administrators has set clear expectations and objectives and will measure management’s performance towards achieving these objectives.

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

There are two versions of the RPM system: one for the Lower Mainland (Richmond) and one for area offices. The main differences relate to the process for inputting data and the timeliness of receiving reports. A user manual is available.

5.3 The RPM provides monthly reports as follows:

- **individual reports:**
  - individual caseload
  - individual open cases
  - individual closed cases

- **summary reports:**
  - office caseload
  - vocational coordinator report
  - summary of open cases
  - summary of closed cases
  - monthly performance reports

The RPM collects information on the number of closures by type. Codes CLS02-07 existed under the VRCSM; codes CLS08-15 were introduced in July 1996.

- **CLS02** old job, same employer
- **CLS03** new job, same employer
- **CLS04** new job, new employer, same industry
• CLS05  new job, new employer, new industry
• CLS06  formal training, new employer
• CLS07  self-employed
• CLS08  unemployed
• CLS09  unemployed, not looking
• CLS10  transfer out
• CLS11  inappropriate referral
• CLS12  commutation
• CLS13  homemaker/temporary PCA
• CLS14  PCA/IHMA
• CLS15  non-return to work intervention.

Performance reports include:

• timeliness and duration:
  • average weeks from injury to referral
  • average weeks from open to IVA
  • average weeks from open to closed
  • average weeks from injury to closed

• return to work and average cost:
  • total return to work closures
  • total non-return to work closures
  • total non-return to work intervention closures

• employability assessments
  • EA received
  • EA complete
  • EA in progress.

The system also collects information on general status, reason for referral, referral source, and injury type.

5.4 An August 1977 analysis of the RPF estimated that vocational coordinators spend approximately 10% of their time maintaining the RPM database and concluded that significant cost efficiencies should be achievable in this area.

5.5 The analysis also identified several problems with the existing system. They include:
• the system is not linked to Claims registration, so all data must be input manually;
• data regarding transferred cases cannot be moved to another desk; it has to be re-entered manually on the receiving desk;
• the person inputting the data (usually a vocational coordinator or case assistant) must rely on the VRC to provide accurate statistical information. Two forms have been developed for this purpose but they are rarely used. When VRCs fail to
provide the required information, the inputer must rely on casenotes or the file; this is time consuming;

- coding options in the system are inadequate, which results in inaccuracies. Codes relating to closure, general status and reason for referral need to be expanded;
- users are unable to query a caseload count without running a monthly report;
- the system introduces inaccuracies in some situations; for example, when a case involving ongoing formal training is transferred, the receiving desk is unable to code the correct formal training start date as the system will not accept a date earlier than the date of transfer.

5.6 Not all VRCs have a common understanding of all codes to ensure that they report on the same basis. In correspondence, the Board has stated that the new code CLS15 is often used for any type of vocational rehabilitation intervention where a return to work is not the focus — rather than other non return to work codes that are more specific. ‘As a result, statistics based on closure codes CLS11 to CLS14 may bear a significant degree of inaccuracy.’

5.7 The RPM does not differentiate between new cases and re-openings of previously referred cases. This was a problem identified during the 1994 Evaluation of back injured workers: the statistics reported through the VRCMS for 1992-1994 include ‘recurring situations in which a worker returns to work but comes back later to receive more benefits’ (i.e. double or triple counting).’

This situation still occurs with the RPM. For example, if an injured worker returns to work in January but is unsuccessful in that attempt and returns to VRS for further services in February, and then repeats that cycle later in the year, that is reported as three returns to work even though only one individual is involved and at least two of these returns to work were not successful i.e. not long term. This type of reporting occurs because the system deals with referrals and openings, rather than with individual clients. Such multiple reporting is misleading. However, it apparently cannot be changed in the current system. It is not known how many cases this applies to. The Director estimates it is less of a problem now than previously. Because many reopenings were due to failed GRTWs, and because adjudicators are involved in Phases I and II, especially for GRTW, these cases are likely nowadays to be recorded on the system.

5.8 It is not known whether clients who return to work through the efforts of VRCs in the Rehabilitation Centre are recorded twice, once in the RPM and again through the Rehabilitation Centre’s reports. If this is happening, interviewees estimate that the number double counted will be relatively small given that injured workers referred to VRS have different kinds of impairments than those referred to the Rehabilitation Centre.

All VRCs regardless of where they are located in the matrix management report all their closures on the RPM. The potential for double counting could be eliminated if all VRCs in the Rehabilitation Centre did not report through the RPM. Management, however, is reluctant to do this because they want a full VRC reporting.
5.9 It seems that not all the information collected through the RPM makes its way into reports. For example, data on the reason for referral has been kept since 1996, yet it was not reported until the end of 1997. A related issue is deciding at which point the purpose for referral is determined. That determination is currently not made until closure and is based on the type of closure. However, the type of closure may not reflect the reason that the referral was made in the first place.

5.10 With regard to performance measurement and reporting, the 1997 RCSD business plan notes that ‘Measurement of the quality and efficiency in which services are delivered to divisions’ clients has become a major focus over the last two years.’ The primary measures currently used in the division for vocational rehabilitation include:

- return to work: the number and percentage of injured workers who have returned to work;
- closures: the number of clients released from the programs

According to the Director, VRS, the Department does report returns to work by desk by month/year. However, she does not consider this a true productivity ratio. There are no timeliness measures for vocation rehabilitation and no measures for outcomes other than return to work.

5.11 The two key performance indicators identified for the Department are:

- improve the safe return to work rate for workers with permanent disabilities by 10% by 2000
- improve the time from disablement to safe return to work by 20% by 2000.

As noted in Hypothesis 1, the bases against which these percentages are to be calculated is not known. This concerns both the Director and her staff.

As far as the research team can determine, the Board has not defined the term ‘safe return to work’. According to the Director, the VRS Department does not collect data to address the second indicator.

5.12 The Case Management Business Case Financial Summary identifies the key performance indicators that will be collected once this initiative is in place. Those relating to vocational rehabilitation include:

- overall satisfaction level with complex case management
- vocational rehabilitation referrals reduced by 5% 1998, 10% 1999, 10% 2000, 10% 2001, 10% 2002
- safe and durable return to work for workers with permanent disabilities increased by 0% 1998, 5% 1999, 8% 2000, 10% 2001, 10% 2002

This set of indicators will be implemented as case management is implemented.
5.13 As above, the bases against which percentages are to be calculated are not stated. Nor has ‘durable return to work’ been defined in the vocational rehabilitation context, although a definition has been used by the Rehabilitation Centre for several years.

5.14 Individual performance indicators were introduced in January 1997. ‘The primary objective of developing performance expectations is to clarify and to communicate standards between managers and VRCs and to ensure consistent levels of client service.’

‘Performance plans are used at the beginning and throughout the review cycle. By clarifying expectations, the VRCs will:

• know what is expected of them
• have input into the joint establishment of performance expectations
• have a basis for regular feedback on their performance.’

The expectations are set out under 9 headings:

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

Six of these have specific time lines attached:

• initial review of file and referral memo: within 5 days of receipt of referral
• initial vocational assessment completed: within 15 working days from receipt of referral; exceptions to be documented on file
• completion of VR planning (initial or final plan) within 13 weeks from receipt of referral
• all employability assessments to be completed within 3 months; any exceptions to be addressed in consultation with Manager and documented on file
• minimum of 2 weeks verbal and written notification to worker of any changes in benefit entitlement
• return client telephone calls within 24 hours.

5.15 To date, only one major program evaluation has been conducted on vocational rehabilitation activities. The Vocational Rehabilitation Interventions Evaluation Study focused on workers with back injury claims and was completed in 1994. The methodology for this substantive evaluation provided a credible, replicable and objective analysis of the delivery, impacts and costs associated with these interventions. It also provided detailed information on outcomes. The fate of the data base compiled during
the study is not known; thus the additional analyses that could have been conducted using it have not been done.

5.16 With respect to specific vocational rehabilitation interventions, only two reviews have been completed to date and they took place several years ago:

- Job search program evaluation, 1991; and
- Business start up review, 1992.

A review of business start ups planned for 1995 was delayed. A formal evaluation through PERU was undertaken in 1997, with a final report expected by June 1998.

A formal evaluation on formal training programs is currently underway through PERU, with an expected completion date of June 1998.

5.17 An Analysis of Vocational Rehabilitation Services and LOE pension awards, dated January 21, 1998, has also been conducted; it is not known which department within the Board is the author. The analysis notes:

Loss of earnings pension awards have increased significantly over the last five years. Simultaneously, vocational rehabilitation expenditures have increased as well. It has been postulated that the increases in vocational rehabilitation expenditures between 1991 and 1994 may have had a direct impact on reducing the number and level of future loss of earnings pensions awards. The objective of this analysis was to investigate the relationships between vocational rehabilitation expenditures and loss of earnings pension awards.

The report concluded:

The analysis suggested that VR RTW expenditures decrease the probability that an LOE pension would be awarded, i.e. the level of gross VR RTW expenditures was significantly related to whether an FNC or LOE pension was awarded on the claims in our sample. Taking into account age at time of injury and pre-injury wages, the higher the level of gross VR RTW expenditures, the more likely that a functional pension was awarded. The probability of an FNC pension being awarded further increased once the number of days of VR services was factored into the regression.

VR RTW expenditures appear to be related to decreased levels of total pension reserves awarded on claims, under certain conditions. The higher the number of days of VR services and the higher the gross VR RTW expenditures, the lower the total pension reserves when VR services are delivered for four years or less. When VR services are delivered on claims for more than four years ... the length of time these services are received appears to mask the relationship between VR RTW expenditures and total pension reserves.
5.18 The Board has not conducted any follow-ups with persons who received vocational rehabilitation services and returned to work. Thus, it is not in a position to assess durability of return to work, however defined. Follow-ups are conducted only for workers who receive Rehabilitation Centre services and similar services offered by external providers.

5.19 The Angus Reid Group is conducting the Customer Satisfaction Survey Project. This project addresses the service challenge as stated in the 1996 strategic plan, to raise client service satisfaction to 85% by 1998. Data on a series of indicators are collected and reported monthly for both the province and by office/SDL. The stream most likely to be involved with VRS is the C (complex) claims. The most relevant information provided through the survey includes:

- the claimant’s frequency of contact with the Board;
- the claimant’s level of satisfaction;
- the claimant’s trust in the claims process;
- the claimant’s rating of WCB doctors and specialists with whom he/she had contact;
- the claimant’s opinion regarding the fairness of policies and procedures; and
- the claimant’s view of the efficiency of the system.

There is no measure relating directly to vocational rehabilitation.

5.20 In an interview, the Director, VRS commented that the Department does not have sufficient management information. There used to be two computer-knowledgeable staff within the Department with specific responsibility for maintaining statistics. In 1997 they were transferred to PERU and their data collection roles were left vacant. Now it seems that the data side of VRS will be subsumed into the centralized statistics kept by the Divisional Controller; however, this has not yet happened. Meanwhile, the Director has no management information/database support within her Department. As a result:

- she cannot plan as effectively as she would like;
- she cannot provide staff with the information they need to retain their focus;
- she fears the Department is missing the ‘big picture’; and
- she is not assured that the data they do have is always reliable.

5.21 The Board is currently in the transition phase for e-file. Management does not want to enhance the RPM now, when it will be replaced by a different version through e-file. However, it is taking a long time to ensure that e-file will be able to deliver the information the Department needs.

5.22 The inadequacies of the Department’s management information system have been acknowledged for some time. For example, the 1994 Evaluation noted
• ‘it does not appear that the information needed to determine whether ... case standards [developed in 1991] are being met is currently being collected. While the VRCMS has a field for ‘date opened’ and fields for the dates employability assessment requests were received and completed, it has none for the initial file review and/or vocational assessment date, for the date when all the employability assessment information had been received nor any dates related to Section 30 referrals. Some of the personal interviewees noted that the standards are not being used as they were intended. They stated that timelines are not being enforced and the Department is not conducting any measurement to determine whether or not these time frames are being met.’

• the board ‘appears to measure the performance of its vocational rehabilitation services primarily through its total expenditures for these services and a single benefit indicator of return to work. These indicators are necessary, but not sufficient, performance measures for Vocational Rehabilitation. In addition, there are some problems with the data being used to report return to work statistics, particularly for claims with multiple re-openings. These statistics should be interpreted with caution.’

5.23 The 1994 Evaluation made three recommendations regarding measurements

16. The Board should revise its performance measures for Vocational Rehabilitation to include:
   · a redefined measure of return to work
   · the frequency with which specific services are being provided
   · relevant outcomes for these services in addition to return to work (e.g. client satisfaction); and
   · the costs associated with providing specific services.

17. The Board should conduct closure interviews with at least a sample of workers who receive vocational rehabilitation services as well as follow up interviews after 6 months, 12 months and/or 24 months to collect information on return to work rates and other service outcomes. Some follow up interviews with employers should also be conducted.

18. The Board should develop an information system which enables VRCs to manage interventions, from referrals to closures, and reduces their documentation requirements. The collection of data for performance measurement purposes should be included as one of the functions of this system.

In correspondence with the commission, the Board notes the following with respect to these recommendations:

16. Performance expectations have been introduced for all VRCs.
17. A formal client satisfaction survey was conducted in 1996 and a follow-up is planned for 1998. As well, follow-up procedures will be introduced in 1998 to measure ‘durability’ of return to work outcomes.

18. E-file, once fully rolled out, will collect all vocational rehabilitation information. Currently this information is collected through the Rehabilitation Performance Management system.

5.24 The analysis of the Administrative Inventories conducted for the commission stated that they were commissioned in order to assess and track the Board’s performance. However, the dimensions and attributes of performance were not defined. As a result it was left up to the individual review teams to define what is meant by performance and how it could be measured. The analysis concluded that the Administrative Inventories were largely unsuccessful in evaluating the extent to which the WCB has achieved its intended results. The major reason cited is the Board’s inability to access credible, current and complete data on outcomes.

5.25 Another project conducted for the commission, the Cohort Project, does not include vocational rehabilitation information because the VR indicators provided by the Board were inadequate. The author of this project concluded that the Board focuses on claims; it does not follow people, hence determining outcomes from an individual claimant’s position is very difficult.

5.26 Performance measures and data collected through the RPM are collected and reported monthly; they are also rolled up and reported quarterly and annually. Angus Reid survey statistics are reported monthly. Other measurement and reporting is generally one-time and sporadic.

5.27 Even when accurate and reliable measurement information is available, there is a concern regarding the extent to which it is used in decision making. Throughout the Administrative Inventories there is a ‘credibility cry’ for the WCB to take advantage of the data available to it, to convert that data into useful management information, to use that information when designing strategies and deciding on policies, and to measure the success and impact of those strategic and policy decisions. The Administrative Inventories warn that if the WCB cannot do this, then its success will be defined by others and it will not be able to demonstrate its accountability to the system’s stakeholders.

5.28 The research team has not found any direct links to show that the results of objective measurement is used to drive planning. This appears to be happening to some extent, but the evidence is indirect.
5.29 Target audiences are not defined in the documents reviewed by the research team.

- The 1994 Evaluation is a public report: however, the Board was unable to confirm how widely it was circulated. Some of the departmental staff were not aware of its existence.
- Studies on the effectiveness of specific interventions appear to be strictly in-house and may have had very limited circulation.
- Data from the RPM appears to be used mostly in-house. It is reported in documents such as business plans.

5.30 The format in which information is presented changes over time making long-term comparison difficult. With the change from the VRCMS to RPM, the unit of data collection also changed, compounding the problems of comparison. This will occur again when the change to e-file takes place.

5.31 There are instances where return to work data is presented in a ‘confusing’ manner; for example, returns to work and retraining have on occasion been reported as one item.

5.32 Newspaper clippings report senior managers at the Board senior managers quoting improved return to work rates. Given the problems identified above, these figures could be misleading.
HYPOTHESIS 6  THE DIVISION IS ACHIEVING ITS OBJECTIVES

Evaluation criteria:

6.1  *the Division is achieving what is set out to do*
6.2  *the programs/services the Division delivers are relevant*
6.3  *the constituencies to which the programs/services are directed judge them to be satisfactory*
6.4  *the Division is able to identify secondary impacts and eliminate those that are negative, and build upon those that are positive*

Conclusions

Hypothesis 6 is not fully supported by the evidence.

Referrals to VRS have been declining steadily since 1994. Of the claims referred in 1996 and 1997, approximately 94% are considered to meet referral criteria.

Only since late 1996 has the Board been collecting data in a systematic way on the reason for referral. While there are some concerns regarding the way this is determined, the Board considers return to work to be a realistic outcome for 65-70% of referrals.

It appears that approximately half of those for whom a return to work is a realistic outcome actually do return to work. There is no benchmark against which to assess this rate of return to work.

The Department does not collect data on the safe and durable aspects of return to work. The only firm data is presented in the 1994 evaluation of vocational rehabilitation interventions for back injured workers. This evaluation suggests that for a significant proportion of the population surveyed, the return to work was neither safe nor durable.

In returning injured workers to work, the VRCs generally appear to follow the hierarchy of phases set out in the manual. The seven principles governing vocational rehabilitation are also generally met; the one that appears to be met least often focuses on timeliness and the Board is taking steps to improve in this area.

The usefulness of services is not known except as determined by the 1994 evaluation. That study found that significant proportions of the survey population did not find their vocational rehabilitation interventions useful.

The Board is measuring client attitudes on a number of aspects including clients’ contact, trust, fairness and satisfaction with their dealings with the Board in general. While no specific questions relating to vocational rehabilitation are currently being asked, C (complex) claims are used as a proxy for claims referred to VRS. For the most part, the scores of C claimants, while
consistently below those of simple claims, are not that different. The one area where there is a significant difference is the issue of satisfaction: 40% of C claimants reported satisfaction (with their dealings with the Board) compared with 77% of Z claimants and 62% of B claimants. The 1994 evaluation found that 39% of the workers surveyed perceived the service they received to be less than what they had expected.

The research team has not seen any evidence that the Department can identify secondary impacts.

**Research Findings and Evidence**

Note: in the following discussion, the reader is reminded of the problems relating to accuracy and reliability identified in Hypothesis 5.

6.1 The Board reports the number of new referrals by year.

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<tbody>
<tr>
<td>Referrals</td>
<td>9,323</td>
<td>9,011</td>
<td>7,672</td>
<td>6,731</td>
<td>7,000</td>
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6.2 The Administrative Inventories note that the number of referrals peaked in 1991 at 11,700, and declined to around 9,000 by 1993. They have been declining steadily since 1994.

In 1997, referrals were 28% below the 1994 level, and approximately 42% below the 1991 level.


Given that the Department tends to deal with the more difficult longer term cases, one might have expected vocational rehabilitation referrals to mirror the LTD claims. They do not; instead, for the years 1991 to 1996, they are in the exact opposite direction.

There are several factors that could explain this. For example, if more permanent disabilities are being suffered by older workers who are more likely to retire than return to work, these claims might not be referred for vocational rehabilitation services. Such analysis is not presented in the documents reviewed by the research team.

6.4 Following the introduction in July 1996 of additional closure codes, the Department is now in a position to determine the percentage of referrals that meet the referral criteria. During the latter part of 1996, this percentage is 94.3%; for 1997 the percentage is 94.1%.
These figures are determined using the closure codes CLS11 (inappropriate referral) and eliminating cases closed under CLS10 (transfer out) from the total number of referrals.

6.5 Since the introduction of the RPM, the Department is also now in a position to determine the number of claims referred and accepted that had previously received vocational rehabilitation services for a different claim. During the latter part of 1996, this figure is 88 out of 4,752 (1.85%); for 1997 the figure is 161 out of 6,083 (2.65%).

In providing these figures, the Department notes that the base on which these percentages is calculated is lower than the number of referrals because a claim may be referred more than once in a given year. The research team notes that this suggests that for 1997, the only year for which full data on all these elements exist, 648 claims (6,731 minus 6,083) were referred to the Department more than once in a given year.

6.6 The VRS Department provides services for three purposes: return to work, quality of life, and employability assessments. Return to work is not an appropriate outcome for all persons referred to the Department.

Until the new closure codes were introduced into the RPM in late 1996, the Board was not in a position to identify the proportion of referrals by reason for referral.

In correspondence with the commission, the Board notes that of the claims referred and accepted:

- return to work was considered a realistic outcome for 65.6% in 1996 and for 70.6% in 1997;
- it is not possible to isolate the number of pension-related VR interventions because the closure code (CLS15) used to capture pension-related referrals can include some non-pension-related referrals; and
- an estimated 4.1% of referrals in 1996 and 4.6% in 1997 were for quality of life reasons only: the Board notes that these figures may bear a significant degree of inaccuracy given the method by which they were determined.

6.7 The Department provides the following statistics relating to closure codes:

- Codes CLS02-07 are return to work codes; data for these codes has been kept for many years.
- Codes CLS08-15 are non-return to work codes. They were introduced in late 1996; 1997 is the only year for which full information on these codes is available. According to the Board, ‘While these codes can be used to generate statistics related to 1996 and 1997 closures, percentage figures must be used if yearly comparative statistics are desired.’
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<tbody>
<tr>
<td>CLS02</td>
<td>875</td>
<td>35%</td>
<td>938</td>
<td>33%</td>
</tr>
<tr>
<td>CLS03</td>
<td>394</td>
<td>16%</td>
<td>514</td>
<td>18%</td>
</tr>
<tr>
<td>CLS04</td>
<td>268</td>
<td>11%</td>
<td>317</td>
<td>11%</td>
</tr>
<tr>
<td>CLS05</td>
<td>503</td>
<td>20%</td>
<td>619</td>
<td>22%</td>
</tr>
<tr>
<td>CLS06</td>
<td>172</td>
<td>7%</td>
<td>187</td>
<td>7%</td>
</tr>
<tr>
<td>CLS07</td>
<td>278</td>
<td>11%</td>
<td>238</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Sub-totals</strong></td>
<td><strong>2,490</strong></td>
<td><strong>2,813</strong></td>
<td><strong>2,527</strong></td>
<td><strong>2,451</strong></td>
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<tr>
<td><strong>RTW codes</strong></td>
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<td>CLS08</td>
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<td>CLS09</td>
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<tr>
<td>CLS15</td>
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<tr>
<td><strong>Sub-totals</strong></td>
<td><strong>3,384</strong></td>
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<tr>
<td><strong>Non-RWT codes</strong></td>
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Note: for 1997, the two sub-totals sum to 5,835; the Department has not provided figures for Codes CLS08-Unemployed and CLS09-Unemployed and not looking.

With respect to Code CLS15, the Board notes that this code ‘was intended to capture any non-RTW intervention that does not fall under codes CLS11 to CLS14. This could include several types of VR intervention (e.g. administrative follow up, employability assessment request, special rehabilitation service request etc.). In practice, however, code CLS15 is often used for any type of VR intervention where a return to work is not the focus. As a result, statistics based on closure codes CLS11 to CLS14 may bear a significant degree of inaccuracy.’
6.8 The Department provides the following statistics on return to work outcomes:

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<tbody>
<tr>
<td>RTW</td>
<td>2,490</td>
<td>2,813</td>
<td>2,527</td>
<td>2,451</td>
</tr>
</tbody>
</table>

6.9 The draft 1998 RCS Division business plan is the first document identified by the research team to present figures on returns to work as a percentage of closures with return to work as an expected outcome.

6.10 In correspondence with the commission, the Board provided data on the number of claims referred and accepted for which the file was closed without a return to work. For 1996 the percentage is 34.7%; for 1997 it is 38.6%.

6.11 The Board also provided data on the percentage of accepted referrals with return to work as the focus in which the case was closed without a return to work. For 1996 this percentage is 34.4%; for 1997 it is 29.4%.

6.12 Based on information presented above,
- in 1997, there were 6,731 new referrals
- for 70.6% of these, return to work was considered an appropriate outcome; this means that 4,752 claimants referred could have been expected to return to work
- the actual return to work cited by the Department is 2,451; as noted in Hypothesis 5, this figure may include multiple returns for some individuals
- it is recognized that work on some claims referred in 1997 is ongoing
- it is also recognized that some of the returns to work will refer to persons referred in years prior to 1996; it is assumed for the purpose of this analysis that the carry over from year to year is approximately the same
- 2,451 returns to work leaves 2,301 referrals in 1997 unaccounted for
- this suggests that approximately half of the persons for whom a return to work is a realistic outcome do not in fact return to work.

6.13 At present there is no indication of whether the Board’s return to work rates are good, moderate or poor. There does not appear to be a national or international benchmark. It is difficult to compare the Board’s figures with those of other jurisdictions or organizations because, as noted in Part 2 of this report, there are fundamental differences between different organizations regarding such factors as referral criteria, duty to accommodate, and economic climate.

6.14 It is difficult to compare the Board’s own figures from year to year due to the lack of consistency in data collection and reporting methods. Figures are sometimes presented without an accompanying narrative that describes the economic situation and other external factors that may affect results.
6.15 The Department does not provide information in its business plan and similar documents on quality of life outcomes.

6.16 The Department provides the following statistics on employability assessments:

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<tr>
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<tbody>
<tr>
<td>New</td>
<td>594</td>
<td>596</td>
<td>815</td>
<td></td>
</tr>
<tr>
<td>Completed</td>
<td>757</td>
<td>885</td>
<td>957</td>
<td>828</td>
</tr>
<tr>
<td>In progress</td>
<td>443</td>
<td>320</td>
<td>360</td>
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6.17 The 1997 Administrative Inventory report commented on the 1996 return to work statistics in detail. The report noted that:

- 2,527 cases had returned to work in 1996 [the research team note cautions that this includes some individuals who returned to work more than once in that time frame]
- 3,927 did not involve return to work.

The report projected that about half of this second group [approximately 2,000] involved non-return to work interventions. 957 employability assessments were conducted during this period. The report concluded: ‘The other half could be regarded as rehabilitation failures. These involve a number of status codes, including unemployed, unsuccessful job search, uncooperative client, non-WCB condition, voluntary inactive, retired, severe disability and other.’

The Administrative Inventory also noted that 48% of the non-return to work closures in 1995 were coded as ‘other’ meaning ‘we do now know what their status was at closure.’ (p.14)

6.18 There still appears to be a group not accounted for. Using the 1996 figures, 2,527 referrals were closed with a return to work coding; 3,927 referrals were closed with a non-return to work coding. This totals 6,454 and compares with 7,672 referrals. Thus, the status of 1,218 is not reported. It is not clear whether all of these are still receiving services. It is also not clear how many active cases are carried over from previous years and what proportion they form of the referrals closed in 1996.

6.19 Apart from the fact that the Board has not defined either safe or durable return to work in the context of VRS, the Department does not conduct follow-up interviews either with workers who have returned to work or with their employers to determine the length of time they remain working or in a specific job, or whether they have changed jobs or
duties due to health reasons, or have quit working. Thus, there is no regular reporting on the safe and durable aspects of return to work.

6.20 The only firm data we have in this regard comes from the 1994 Evaluation. It is presented in detail below to indicate the complexity of determining safe and durable rtw.

Of the 568 workers in the Evaluation study population who recalled receiving services as a result of their referral to VRS (p.29), 333 (59%) reported that they returned to work during or at the same time as their vocational rehabilitation interventions finished. Of these 333, 149 (45%) were, at the time of the survey, still working in the job they returned to and 184 (55%) not still working in the job they returned to.

Of the 184 not still working in the job they returned to:

- 32% remained over one year
- 17% remained 7-12 months
- 47% remained 6 months or less
- 70% were no longer in the job they returned to because injury or illness made it too difficult to perform the job responsibilities (54%) or because of too much pain (16%).
- 40% reported that they had been employed most/all of the time since ready to return to work and 15% employed about half the time.

These figures suggest that at the time of the survey at least, many returns to work for this particular population were neither safe nor durable.

6.21 The Policy Manual presents a hierarchy of five sequential phases which VRCs are to follow in their attempts to return claimants to work. These correspond directly to closure codes CLS02 to CLS06. On the surface, one might expect the percentages to decrease from the highest in CLS02 to the lowest in CLS07. This does not happen, likely due to the fact that some injured workers can no longer work in the same occupation or industry.

6.22 The 1994 Evaluation confirms that at that time at least, efforts were made to follow the hierarchy of phases:

Of the 333 who rtw: (p.52)

- 73% returned to their same employer
- 22% returned to a different employer
- 5% self-employed
- 54% returned to their same job
- 16% returned to a similar kind of job
- 30% returned to a different job
• 44% returned through GRTW
• 36% went directly to permanent full-time positions
• 5% went to temporary full-time positions
• 14% went to either temporary or permanent part-time positions

6.23 In the 1997 Administrative Inventory, the authors, using partial data for the three year period 1994-96, commented that there was a trend as follows:

• CLS02 closures (old job) is steady
• CLS03 closures (old employer, new job) fluctuates widely
• CLS04s and CLS05s closures (new employer old job, and new employer, new job) are up dramatically.

The Administrative Inventory concluded: ‘These trends lie behind recent allegations by injured worker advocates that the WCB has abandoned its authorized policies on VR’.

However, full data for the years 1994-97 reveals a high degree of consistency from year to year in the percentages of closures by return to work codes (CLS02-07). The largest fluctuation is 5%.

6.24 Another aspect of successful rtw is the wage level to which workers return. Where it is less than their wage level at the time of disability onset, the board is liable for making up the difference. As far as the research team can determine, the board does not report this information, although it must be known because the board knows how many pensions it pays.

The 1994 Evaluation found that of the 333 workers who returned to work:

• 57% returned to same wage level
• 13% went to higher wage level
• 28% went to lower wage level

6.25 The Board’s policy is to deliver ‘Quality rehabilitation’ (see Hypothesis 1). The Board established seven principles to guide quality rehabilitation.

The following presents research that demonstrates the extent to which these principles are adhered to. Without a review of individual files, it is not possible to determine the extent to which these principles are met. However, the research team found some evidence relating to the application of these principles.

1. *Timeliness and early coordination with medical and physical rehabilitation.* The importance of timeliness is stressed in virtually every related document we reviewed, regardless of source. The figures are: 50% after 6 months, 10-15 % after 1 year, and
virtually nil after 2 years of being out of the workforce. (Source: Anderson, GBJ, The intensity of work recovery in low back pain, Spine 1983. 8:880-4)

Following the introduction of performance measurement, the Division now reports on several aspects of timeliness regarding claims management. However, it does not report on timeliness of referrals to VRS. The Director of VRS agrees this type of data is necessary and would bring her Department more in line with Claims in terms of timeliness measures; two managers are currently working on this issue.

The 1994 Evaluation found that referrals were driven by medical ‘plateaus’ and wage loss terminations. ‘At least two-thirds of the back-injured workers whose files were reviewed were referred to VR within a year of their injury occurring. While the majority of these workers were referred before their wage loss benefits finally ended, almost one-quarter ... were made after this time.’ Personal interviewees felt that ‘most of the time referrals came too late ... some referrals are reportedly made well past the ‘two years after injury’ mark.’

The WCB’s report Case Management: A Developmental Overview and Preliminary Results noted that ‘for the six claims referred to VR [under the case management prototype], the referral for services was initiated, on average, within 72 days from date of injury. This is in contrast to the Prince George office average, where for the same period of time, referral was initiated within 882 days from date of injury.’ The research team cautions against accepting this statement at face value until it is determined whether, for example, the 882 figure includes persons referred for pension settlement reasons (which would automatically extend the referral period), whether the six persons referred under case management would likely also have been referred under the traditional referral system, and whether indeed there are others who were not immediately referred but who were referred subsequently. Nevertheless, the difference between 72 and 882 is startling and suggests that under the traditional system, vocational rehabilitation services relating in particular to return to work were not always delivered on as timely a basis as they could have been.

2. **Workers to be motivated.** The board does not report on this facet and there is no easy way to determine the extent to which workers are denied services, if at all, because they are considered not motivated. In an interview, the Director VRS noted that motivation continues to be an issue with the Panel of Administrators, particularly with respect to Code R payments.

3. **Different approaches be used in response to the unique needs of each individual.** The board offers a range of services that is in keeping with the range offered by other rehabilitation providers. As shown in Part 2 of this report, it appears to be more inclusive than many other providers e.g. in terms of providing funding for business start ups and the breadth of counselling.

4. **Collaborative approach.** Case management has been set up in part to respond to problems identified with this principle.
5. **Workers’ personal preferences and workers’ accountability for independent vocational choices and outcomes.** The research did not reveal any conclusive evidence. In the Director’s opinion, most VRCs do consult with clients and involve them in developing plans.


7. **Rehabilitation should not be provided when the primary obstacle to a return to work is non-compensable.** The Director, VRS advises that non-compensability is determined by claims adjudicators. If a client has been referred and accepted for vocational rehabilitation services and then develops a problem that interferes with those services, then the case is sent to a claims adjudicator for review. The requirement for re-assessment is not frequent.

6.26 Case management is designed to address, *inter alia*, the facets of quality rehabilitation. The fact that this has become necessary suggests that there have been significant problems with meeting all or some of the attributes of quality rehabilitation.

6.27 Apart from a 1991 Review of the Job Search Program, a 1992 Review of Business Start Ups and the 1994 Evaluation, the Division has not evaluated the impact of specific interventions and thus does not know their effectiveness in meeting objectives and hence their relevance. Evaluation of formal training and business starts up is underway.

The 1994 Evaluation looked at the effectiveness of specific vocational rehabilitation services. The multiple regression analyses found that:

- vocational rehabilitation services that were directly related to jobs, including temporary changes to job duties and physical changes or modifications to the work site, were the most effective in meeting vocational rehabilitation objectives;
- also effective, but to a lesser extent, were services related to finding a job.

However, the Evaluation noted that many services did not show up consistently enough in the analysis to conclude that they are being effective.

6.28 As regards the usefulness of vocational rehabilitation interventions, the 1994 Evaluation found that:

- of the 333 workers in the study who had returned to work, 52% stated that the vocational rehabilitation services they received ‘did not help them to return to these jobs at all.’
- 28% of the back-injured workers who received ‘other’ services such as equipment rentals and modifications, help with travel costs or home care allowances said
they did not help at all, and 13% said these services were not related to their daily living needs.

- 74% of the 64 employers surveyed who recalled workers who had returned to work, considered the WCB’s vocational rehabilitation services to have helped achieve this outcome. In particular, these services reportedly helped to speed up the return to work. Employers stated that in 16% of cases, the vocational rehabilitation provided did not help at all and 11% were not sure if the services had contributed to the return to work.
- 39% of the 62 back-injured workers who recalled an employability assessment being conducted for their claim, said that it helped them obtain a fair pension settlement; 27% said that these services did not help at all.

6.29 As described in Hypothesis 9, the Board may pay its vocational rehabilitation clients benefits while they are in receipt of services. Some of these are wage-loss equivalency benefits; the rest are non-wage loss equivalency. The level of payment is determined on an individual basis by VRCs and their managers.

6.30 There are individual appeals regarding the amount of benefits received. The Board does not collect and analyze appeal information by type of vocational rehabilitation service; thus we cannot determine from this source if there are specific benefits being appealed.

6.31 The 1997 Administrative Inventory noted that there have significant reductions in vocational rehabilitation expenditures. According to the report, some critics assert that these decreases demonstrate the reduced attention to the legitimate needs of injured workers and are resulting in the ‘walking wounded’.

6.32 Much of the benefits payment debate has focused on Code R—Income Continuity benefits. The Board applies a dual system to assess permanent partial disability pensions (section 23(3) of the Act), based on a projected-loss-of-earnings and a loss of functions. To project loss of earnings, an employability assessment is required. VRCs conduct these assessments.

Until recently, there has been a backlog of employability assessments, which has presented a major challenge to the board (Hunt 1997:16) in part centering on the high Code R (income continuity payments) that were incurred as a result of this backlog, Code R payments, which were introduced in 1987, have had a checkered history. As shown in the following table, the amounts spent on them have fluctuated enormously:

**Code R — Income Continuity Expenditures**

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<tr>
<td></td>
<td>$3.7m</td>
<td>$2.9m</td>
<td>$6.9m</td>
<td>$8.5m</td>
<td>$7.5m</td>
<td>-$0.2m</td>
<td>-$1.7m</td>
</tr>
</tbody>
</table>
The Code R benefit used to be set at the temporary wage loss benefit level, which was generally higher than the ultimate permanent pension benefit and any overpayments were to be recovered once the actual pension was determined. A 1992 audit showed that less than half the Code R overpayments were in fact recovered from permanent pension awards.

During 1995 and 1996 there was an internal debate within the WCB on how to handle Code R benefits, a debate initiated by a ‘policy analyst who became convinced that the routine practice of extending Code R benefits to clients awaiting pension determinations, regardless of vr status, was illegal’ (p.38). As a result the practice was changed: the Code R benefit was set at the estimated permanent pension benefit, which is generally significantly lower than the temporary wage loss benefit level. ‘Thus, the VRC gives immediate effect to his or her EA by implementing a Code R benefit based on the hypothetical earnings that have been assigned.’ As Hunt noted, ‘It is this specific change which is the subject of labour’s outrage. Rather than continue weekly wage loss payments at the temporary disability benefit level, the WCB is moving immediately to lower weekly payments to the estimated pension level.’

As noted above, net Code R benefits were actually negative for fiscal year 1996 and 1997. 1995 to 1996 saw a swing from $7.5m to minus $243,270. ‘This swing of nearly $8 million in expenditures in one year’s time has certainly caught the attention of the stakeholder communities.’ WCB Management ‘anticipates that Code R payments have now been reduced to approximately a break-even basis for the indefinite future.’

6.33 Another concern relating to employability assessments is the process of deeming. Where a claimant has not returned to work at the time of fixing the permanent loss of earnings pension level, it is necessary to determine an estimate of the earnings loss. In these cases, deeming of jobs occurs. The problem is that ‘deeming not only requires estimating the effects of the permanent impairment, but also the labour market implications of that impairment.’ The exercise is intended to determine ‘suitable and available jobs’. This creates much opportunity for differences of opinion and dispute.

6.34 There has been a level of dissatisfaction with Board activities in general; this has been documented several times over the last several years. For example:

- 1992 Canadian Facts survey of workers and employers
- responses by stakeholder groups during the Strategic Planning process 1995 and 1996
- an Angus Reid survey of employers conducted February 1997 just prior to the launch of the case management prototype
- the 1997 monthly Angus Reid surveys of C, Z, B and Y claimants.

These documents collectively show a polarization in satisfaction levels: some workers and employers are very pleased with the way the Board operates and the service they receive; others have a litany of complaints. To a large extent, those with shorter claims
and less contact with the Board are more satisfied; those with longer, more complex
claims are less satisfied.

Employers are dissatisfied with claims administration, which they feel is too slow; they
want more involvement and would prefer more individualized attention and
communication from staff.

The most commonly noted concerns among workers include long administrative delays,
multiple “hand-offs” among officer level staff, poor communications, and unclear
processes and roles.

Attending physicians and other service providers have also expressed a level of
frustration with the current system.

Recent surveys by Angus Reid have shown the WCB is perceived by the public to be one
of the least well managed organizations among those surveyed.

6.35 The 1994 Evaluation provides detailed information on satisfaction levels (at that time)
with vocational rehabilitation services in particular. It included surveys of workers and
employers, detailed analysis of their responses to open-ended questions, and an analysis
of the service quality gap. The study confirmed the polarization of views. It found that
39% of workers perceived the service they received to be less than what they had
expected. For example:

- in terms of client satisfaction with service delivery, 17% were not very satisfied
  and 23% were not at all satisfied with these services. 33% were somewhat
  satisfied; and 22% were very satisfied;
- while 55% way they were treated fairly through the process 42% either somewhat
  or strongly disagreed with this statement.

This level of dissatisfaction may be higher than for the board as a whole and reflects the
fact that the study focused on back-injured workers.

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

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

6.37 The Board has commission Angus Reid to conduct surveys to determine whether its
clients are satisfied with the services they receive. Results are reported by type of
claimant. C claimants are those with complex claims; while not all C claimants receive
vocational rehabilitation services, we use this groups as a proxy for workers referred to vocational rehabilitation.

Results for week 13 (W13) of the Angus Reid survey showed the following results for C claimants in comparison with B and Z claimants:

- C claimants have more contact (6 or more points of contact)
- Fewer C claimants (40%) reported satisfaction than Z (77%) or B (62%) claimants
- Fewer C claimants (79%) have trust in the claims process than Z (93%) & B (85%) claimants
- C claimants (70%) are less likely to feel that their doctor’s opinion was respected (% for Z and B not given)
- Fewer C claimants (77%) considered policies and procedures to be fair compared with Z (88%) and B (87%) claimants
- Fewer C claimants (72%) considered the system to be efficient compared with Z (88%) and B (89%) claimants.

As C claimants are those who are more severely injured or whose recovery has been delayed, the lower satisfaction level could be anticipated; however, at least one expert considers these results good.

6.38 Case management may be improving this satisfaction rate. Angus Reid surveys based on the 49 claimants who in the period May 1-July 1997 had their claim processed through case management in the Prince George prototype show:

- worker satisfaction: 23% increase over the baseline rating for provincial ‘C’ claims in 1996, 13% increase over current ratings for provincial ‘C’ claims
- satisfaction with business processes: 27% increase over the baseline rating for provincial ‘C’ claims in 1996, 15% increase over current ratings for provincial ‘C’ claims.

6.39 The research team has seen no evidence to demonstrate that the Board or Division is able to identify secondary impacts and eliminate those that are negative.

6.40 The 1994 Evaluation identified worker outcomes other than return to work that could result from the provision of vocational rehabilitation services. These include:

- learning how to avoid re-injury: 65% of those interviewed stated they had been helped in this area a great deal;
- managing the emotional strain resulting from their injury: 28% stated the services helped them somewhat or a great deal in this regard; 47% reported that they did not help at all; 23% stated this was not part of the services they received
The research team is not aware of any other similar analyses conducted or reported by the board.
HYPOTHESIS 7  THE DIVISION IS ACHIEVING ITS OBJECTIVES IN A COST-EFFECTIVE WAY

CCAF attributes:  6, 8 (in part)

Evaluation criteria:

7.1 the Division is able to identify costs, inputs and outputs and determine the relationship between them
7.2 the Division conducts the necessary analyses to determine if it is achieving its results at a reasonable cost (i.e. is efficient and economical)

Conclusions

There is insufficient evidence to determine whether Hypothesis 7 is met or not.

The Board is unable to determine whether it is achieving its results at reasonable cost because it is not able to identify all inputs (including overheads); nor can it determine the relationship between inputs and outputs. Thus the cost effectiveness of vocational rehabilitation services is not known.

This finding is confirmed by the 1994 Evaluation, the 1996 Administrative Inventory, and the 1997 Office of the Auditor General’s Accountability Review, in which it was stated that administration and cost effectiveness should be better measured and reported upon. It is also confirmed by staff: they have an intrinsic belief that the services they provide are cost effective, but such analysis has not been conducted.

Since it cannot determine total inputs, the Department therefore cannot determine whether it is more cost effective to purchase similar services from external services as opposed to providing them internally. It is also not in a position to compare its costs and outcomes with those of other rehabilitation service providers/funders within BC and elsewhere.

The 1998 Corporate Plan includes steps to address this situation. The extent to which it is successful will depend in large part on ensuring that the appropriate items for measurement and reporting are determined.

Other board initiatives such as e-file and the Data Warehouse project may also assist in improving cost-effectiveness.

Research Findings and Evidence

7.1 The 1994 Evaluation concluded that it was not possible to conduct the cost-effectiveness analysis outlined in the evaluation terms of reference because of a lack of data. To do this analysis would have required information on the levels of services provided and their outcomes and costs. Costs include both administrative costs and rehabilitation-related
expenditures. The board’s overheads, an essential part of costs, are not accounted for by service or by function.

7.2 The 1996 Administrative Inventory used detailed evidence to support its views about ‘exploding’ costs that were increasing at an ‘alarming’ rate. It noted that increases in administrative costs were not matched by corresponding increases in productivity nor in outcomes. It warned about increasing costs and called for more explanation and analysis into why this was occurring.

7.3 The 1997 Office of the Auditor General’s Accountability Review stated that administration and cost effectiveness should be better measured and reported upon.

7.4 In interviews, staff have confirmed that the Board is not in a position to determine its cost effectiveness: they have an intrinsic belief that the services they provide are cost effective, but such analysis has not been conducted. In correspondence with the commission, the Board has confirmed this.

7.5 The board’s 1998 corporate business plan notes:

In order to properly address administration cost effectiveness, the Board needs to examine its costs in unit of production terms and relate that to the performance criteria. For example, the unit cost for processing each health care only claim would be related over time to performance criteria ... against similar costs at other institutions.

The Board’s financial and accounting systems have to be re-aligned to more properly express the operations of the Board. To determine unit costs of production, payroll costs (almost 75% of total administration costs) should be related to function and outputs rather than to departments. For example, all salaries and wages for a SDL are currently charged to the SDL service centre under a wage expense code. Although the SDL handles many different types of cases and produces several outputs, it will not be possible to measure unit cost of output until wage and output information is captured separately and measured consistently over time.

7.6 The kinds of data required to determine cost effectiveness of vocational rehabilitation services for return to work and pension related activities would likely include:

**RTW services**

Claimants:
- the number of claims referred per year for whom return to work is a realistic outcome
- the number of individuals provided with vocational rehabilitation services per year
- the number of returns to VRS per claim (i.e. referrals vs re-openings)
• time from disablement to receipt of vocational rehabilitation services.

Outcomes:
• the number of times each claimant returns to work and the length of each return to work (i.e. to eliminate any double or multiple counting of return to work)
• the length of time the worker remains at work after the last return to work
• the salary level the worker ultimately realizes upon last return to work.

Benefit/Pension implications:
• the value of benefits paid while receiving vocational rehabilitation services
• the amount of any pension still payable upon return to work.

Attribution:
• the extent to which provision of vocational rehabilitation services contributed to the return to work
  • whether the worker would likely not have returned to work without these services
  • whether the worker would likely have returned to work without these services, but at a later date; if so, how much later; need to analyse the cost of services relative to the speeded up return to work
• identification of major external factors e.g. economic climate that could affect outcomes.

Costs:
• direct total VRC time/costs attributable to each worker
• direct total vocational rehabilitation services costs attributable to each worker
• % of all Board overheads (such as building and infrastructure, utilities, board governance).

Pension-related Services
• average time/cost to prepare an EA for a s.23(3) permanent partial disability or for a section 30(1) temporary partial disability benefit
• percent meeting or exceeding the average.

Quality of Life Services

It is not clear without further research what factors would be used to determine the cost/benefit and cost effectiveness of quality of life services.

7.7 As noted in hypotheses 5 and 6, some of this information is currently collected by the Board; however, there are some concerns regarding its accuracy. A major limitation is the current inability to distinguish between new referrals and reopenings, which results in the potential for multiple returns to work to be reported for one claimant on one claim.
More importantly, much of this type of information is either not collected or not collected in a format that is amenable to this type of analysis.

7.8 With respect to the relationship between administrative inputs and program outputs, the Board does track the number of referrals by VRC desk; this information is presented in caseload reports, but it is not, according to the Director, VRS, rolled up well.

The Rehabilitation and Compensation Services Division business plans report on the number of returns to work per VRC desk and returns to work as a percentage of referrals:

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</thead>
<tbody>
<tr>
<td>RTW per VRC desk</td>
<td>36</td>
<td>36</td>
<td>32</td>
<td>38</td>
<td>40</td>
</tr>
<tr>
<td>RTW as % of Referrals</td>
<td>26.7</td>
<td>31.2</td>
<td>32.9</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The 1998 business plan cites a new statistic: ‘RTW as a percentage of closures with rtw as expected outcome.’ This statistic is not available for years prior to 1997. The 1997 forecast is 70%. While separating closures by type of expected outcome is more meaningful in determining cost effectiveness, it does not, as far as we can determine, deal with the issue of re-referrals and the possibility of double or multiple counting. There is also a question of when the expected outcome is determined. Interviewees reported that the determination is made at the time of closure and not at the time of referral.

7.9 Other board initiatives may assist in improving cost-effectiveness. E-file, for example, will allow ‘simultaneous access of files’ and enable ‘the development of new, interactive and efficient claims processes’. Case management also has improved cost control as an objective. One question that has to be addressed regarding the cost effectiveness of case management is whether the cases being referred for vocational rehabilitation through case management would likely have been referred under the current system.

We are advised that the new Research Unit has analyzed various factors that contribute to cost. In addition, the ‘Data Warehouse’ project is intended to result in more access and more linkages between data bases, which presumably should assist in making cost effectiveness calculations.
HYPOTHESIS 8  THE DIVISION IS DETERMINING FUTURE NEEDS AND MAINTAINING THE CAPACITY TO DELIVER RESULTS IN THE FUTURE

CCAF attributes: 7, 11 (in part)

Evaluation criteria:

8.1 the Division has the ability to maintain or improve results
8.2 the Division has identified the capacity (staff, external contractors etc.) to deal with the future, so that it is protected from the danger of losses that could threaten its success, credibility and continuity
8.3 the Division is positioned to adapt to changes in such factors as markets, competition, available funding or technology

Conclusions

Hypothesis 8 is generally supported by the evidence.

To the extent that outcome data is accurate, the Department does appear to be maintaining if not improving its results.

Staffing levels are to remain constant in 1998 whereas the anticipated number of referrals is expected to decline. This suggests that the Department should have sufficient capacity to focus on return to work outcomes and to further reduce the inventory of employability assessments.

The Department is seeking to improve its third party provider network and associated contracting arrangements.

Departmental staff are involved in other major initiatives in the Board, which should enable the Department to respond to them.

A continuing lack is the absence of a labour market analyst who would maintain up to date information on behalf of all VRC staff.

Research Findings and Evidence

8.1 The Board does not have the data to compare over time returns to work for referrals for whom a return to work was a realistic outcome.

A comparison of returns to work as a percentage of new referrals for the years 1994 to 1997 shows the following:
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New referrals</td>
<td>9,323</td>
<td>9,011</td>
<td>7,672</td>
<td>6,731</td>
</tr>
<tr>
<td>Returns to work</td>
<td>2,490</td>
<td>2,813</td>
<td>2,527</td>
<td>2,451</td>
</tr>
<tr>
<td>RTW as % of new referrals</td>
<td>26.7%</td>
<td>31.2%</td>
<td>32.9%</td>
<td>36.4%</td>
</tr>
</tbody>
</table>

This proxy suggests that the Department is improving its return to work outcomes over time.

8.2 The Board is increasing the number of employability assessments completed each year.

8.3 The 1998 VRS Department business plan notes that the number of active VRC desks will remain constant over the next year, although new referrals are anticipated to decline. It appears that departmental staff will thus be able to spend more time with individual clients in an attempt to achieve higher return to work rates, and to reduce the inventory of employability assessments.

8.4 The business plan notes that ‘staffing impacts of case management on the VRC’s are unknown at this time, but it is anticipated that their role will change in keeping with the key principles in the case management model’.

8.5 The business plan also notes that ‘the department’s management team will be augmented at the senior manager level to more appropriately address the challenges of a decentralized matrix management model in providing technical/professional oversight’.

8.6 Professional development of departmental staff is an important focus for the Director. Topics discussed at the spring and fall professional development sessions focus on problems encountered by VRS staff.

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

- successful integration of vocational rehabilitation into the case management model
- development and management of a comprehensive external provider network
- on-going professional development in key areas of vocational rehabilitation practice
- monitoring and supporting clinical supervision within a matrix management model
- improved client satisfaction as measured through formal surveying.
8.8 Weaknesses identified in the 1998 business plan include:

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

Issues relating to the statistical reporting system and to matrix management are discussed elsewhere in this report.

With respect to the second weakness, the Director, VRS noted in an interview that she would like to have a labour market/economist/business analyst on staff; however, to date it has not been a sufficiently high priority. This suggestion was previously included in the 1994 Evaluation report.

8.9 Effective May 1998, the Department has hired a manager who is tasked with improving its third party provider network and related contracting arrangements.

8.10 Departmental staff are involved in the major initiatives being pursued by the Board, which should ensure the Department is in a position to respond to them. These initiatives include disability management, case management, e-file and data warehouse.

8.11 Initiatives are underway to assess the effectiveness of specific interventions. This type of analysis should enable the Department determine which services are most likely to have the best outcomes for specific clients.
HYPOTHESIS 9  THE DIVISION HAS SET AND IS ACHIEVING ITS FINANCIAL OBJECTIVES

CCAF attributes: 8, 11 (in part)

Evaluation criteria:

9.1 the Division has set financial objectives
9.2 financial objectives are cognizant of and developed using the measurement of actual performance (i.e. performance information is the basis on which financial decisions are made, OR: performance measurement has a direct impact on budgets)
9.3 the Division keeps complete and accurate financial records and can account for revenue and expenditures, and for the valuation of assets, liability and equity
9.4 the Division determines and reports on a regular basis whether its financial objectives are being met
9.5 the Division takes the steps necessary to address any variances identified
9.6 the Division manages its financial responsibilities according to sound financial controls
9.7 the financial information is subject to verification/audit

Conclusions

Hypothesis 9 is generally supported by the evidence.

The Department sets budgets which the Division considers to be its financial objectives. Budgets cover two areas: expenditures related to the vocational rehabilitation services (program costs) and administration costs. Although there is a budget for program costs, in fact the Board pays whatever is considered necessary by its professional staff to meet the vocational rehabilitation needs of individual clients. In recent years it has stayed within budget.

Performance measures are considered in the budget setting exercise and are reported on the relevant budget work sheets. However, as noted elsewhere, the extent and reliability of performance measures could be improved, which in turn would improve the budgeting process.

The Department has established a series of codes for tracking expenditures. While it maintains records by code, it reports by groups of codes. Further, the number of codes has increased over time as the system has become more sophisticated and such changes are not always reported in the business plans. Both these facts hamper comparison and tracking over time. An earlier audit also noted problems with tracking vocational rehabilitation expenditures.

The Department reports financial matters in the RCS Division’s annual business plans. The Department also used to report on a quarterly basis in the Compensation Services Division Performance reports. However, those reports were not always complete with respect to VRS activities and expenditures.

The narrative sections of the business plans do present some explanations for variances.
Audits and follow-up audits have been conducted; recommendations are generally implemented.

**Research Findings and Evidence**

9.1 Although the Department does budget for vocational rehabilitation service-related expenses and benefits, the Director, in an interview, advised that no limit is set on what is spent. Actual expenditures are determined by individual VRC’s and managers and are based on the needs of individual injured workers. It is left to the discretion of staff to determine when ‘enough is enough’.

9.2 The Department tracks benefit expenditures by type. A distinction is made between wage-loss equivalency benefits, non wage-loss equivalency benefits and other benefits. Benefits are coded as follows:

**WAGE-LOSS EQUIVALENCY**
- E Job search allowance
- G Formal training allowance
- H Work assessment
- R Income continuity
- U Rehabilitation assistance while ‘planning’
- Y Training on the job

**NON WAGE-LOSS EQUIVALENCY**
- F Subsistence
- J Course fees, books, supplies
- K Travel
- M Miscellaneous
- N Homemaker
- S Business start up
- T Third Party Contract

**OTHER BENEFITS**
- Long term personal care
- Short term personal care
- Independence and home maintenance allowance

9.3 The automated wage loss payments system produces several reports on behalf of the Department. Examples are:

- report WLS2630-6100: number of cases in receipt of rehabilitation expenditures (summary); and
- report WLS1640-6100: refund to the Rehabilitation Department.

Both of these reports are produced monthly and provided to the Director, VRS.
9.4 The Department reports benefit payments. In the Division’s 1997 business plans these are aggregated as follows:

<table>
<thead>
<tr>
<th>BENEFIT PAYMENTS</th>
<th>1994 Actual</th>
<th>1995 Actual</th>
<th>1996 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Search (codes E&amp;U)</td>
<td>23,538</td>
<td>25,504</td>
<td>21,561</td>
</tr>
<tr>
<td>Formal Training (codes G&amp;J)</td>
<td>14,538</td>
<td>14,637</td>
<td>12,638</td>
</tr>
<tr>
<td>Work Assessment (codes H&amp;Y)</td>
<td>4,472</td>
<td>4,885</td>
<td>4,517</td>
</tr>
<tr>
<td>Income Continuity (code R)</td>
<td>8,486</td>
<td>7,536</td>
<td>(243)</td>
</tr>
<tr>
<td>Business Start-ups &amp; 3rd Party (codes S&amp;T)</td>
<td>-</td>
<td>551</td>
<td>1,584</td>
</tr>
<tr>
<td>Other (codes F,K,M&amp;N)</td>
<td>14,728</td>
<td>8,168</td>
<td>3,326</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>65,762</strong></td>
<td><strong>61,281</strong></td>
<td><strong>43,383</strong></td>
</tr>
</tbody>
</table>

The aggregation in the 1997 Business Plan is slightly different than that presented in the 1996 Business Plan, where ‘Other’ includes codes F, K, L, M, N and P. At that time, business start-ups and third party contracts were not separate codes.

9.5 In the Board’s presentation to the commission hearings March 4, 1998, these expenditures were aggregated as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Assistance</td>
<td>23,538</td>
<td>22,181</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal Training</td>
<td>14,538</td>
<td>14,637</td>
<td>12,638</td>
<td>13,247</td>
</tr>
<tr>
<td>Work Assessment</td>
<td>4,472</td>
<td>4,885</td>
<td>4,517</td>
<td>3,784</td>
</tr>
<tr>
<td>Other</td>
<td>26,059</td>
<td>22,393</td>
<td>17,509</td>
<td>17,769</td>
</tr>
</tbody>
</table>

9.6 This method of presentation makes it impossible to track payments by individual code over time.
9.7 There is also a discrepancy between the actual totals for 1994 and 1995 as reported in the 1996 Business Plan and those in the 1997 Business Plan because the 1996 document includes a code P, but the 1997 document does not. This kind of problem adds to the difficulties in tracking payments by individual code over time. The accompanying text in the Business Plans does not refer to or explain changes in presentation.

9.8 A comparison of actual total benefits paid relative to budget shows that in 1995 and 1996 actual expenditures were lower than budgets, and in the case of 1996, significantly lower.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>BUDGET</th>
<th>ACTUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>64,760</td>
<td>64,096</td>
</tr>
<tr>
<td>1996</td>
<td>61,000</td>
<td>43,383</td>
</tr>
</tbody>
</table>

The business plans include brief narratives regarding differences between actual and budgeted expenditures.

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

9.10 The RCS Division business plans do provide some explanations for variances. For example, the 1997 business plan notes:

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

9.11 The Division budgets for administration expenses. In the Business Plans, expenses related to the VRS Department are not separated from other Claims. Thus it is not possible from these public documents to determine VRS salary costs and expenses. Nor is it possible to identify Departmental staffing levels. This information is tracked by the Board but not incorporated into its business plans.

9.12 Departmental systems now allow for the tracking of new claims, referrals, return to work outcomes (return to work, non-return to work, claims in progress), employability assessments (referred, completed, in progress) by SDL. These figures can then be compared with the number of VRCs in each SDL to arrive at some form of productivity ratio by SDL.

As far as we can determine, data at this level of detail remains internal to the Board.
Our analysis of this data for the period ended December 1997 showed that while almost all SDL’s reported this information, there were some gaps; also, SDR East and SDR West appear to report differently from each other. Thus, comparison between the SDL’s is hindered.

9.13 The research team has identified the following audits conducted by the Board’s Internal Audit Department that relate directly to VRS program expenditures.

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

9.14 The Code R audit noted:

‘Unrecovered Code R benefits may be regarded as one of the costs associated with delays in establishing pensions. Pending the implementation of improvements which reduce the time required to establish a pension, however, significant reductions in these costs may be possible by improving guidelines pertaining to Code R eligibility and payment rates. These latter components of the cost of delays are the focus of this audit.

‘... the findings in this report were obtained through systems-based investigations and have not been verified through physical claim file reviews. Due to this limitation, it was necessary to assume that benefits paid under Code R were intended as income continuity benefits. We acknowledge that in some cases benefits paid incorrectly as Code R may have otherwise been disbursed under other rehabilitation codes.’

The audit made 17 recommendations. Vocational Rehabilitation Management’s response is attached to the audit report. At the time of the follow-up audit, the Director, Internal Audit reported ‘Based on written responses received from the Director, Vocational Rehabilitation, we have determined the status of actions taken in response to our original recommendation to be satisfactory. A list of the recommendations which are currently in progress or which appear to require further attention has been attached.’ Only three recommendations are listed and action was underway on all of them.

9.15 The Vocational Rehabilitation Committee audit included a review of the Committee’s structure, mandate and responsibility in the current vocational rehabilitation approval process. It included an audit test of approvals for expenditures which were referred to the
VR Committee in 1993. A sample of 14 claims, corresponding to 15 budgets totaling approximately $1.3 million was selected for review on a judgemental basis.

The audit made 13 recommendations. The follow up audit notes that three recommendations are outstanding; however, action has been taken on all three.

9.16 The audit entitled Vocational rehabilitation third party service providers review covered payments to outside parties from 1990 to 1994 for the provision of assessment, testing, counselling and job placement services. ‘Although these service fees constituted a relatively small proportion of the total vocational rehabilitation expenditures, attention is required due to the rapid increase in these types of payments. In 1994, $1.57 million was paid to third party service providers, which was double the 1993 figure.’

The audit found that ‘A major difficulty in tracking rehabilitation expenditures is that a great deal of information is not readily available from the existing AWL system. For example, reports on payments by type of service or by payee cannot be obtained directly from the system. Currently, extensive data analyses are required to compile such figures. The shortcomings of the existing system in management reporting has been reiterated a number of times in internal VRSD reports and in previous audit reports.’

As a result of this audit, VRCs were required to follow the Board’s purchasing policy regarding Third Party Providers. An e-mail was circulated to all staff regarding this matter and a copy of the short form contract was made available to each individual VRC. The Vice President of Compensation Services has delegated signing authority for contracts of $10,000 or less to the managers of the Division. In future, all contracts will be reviewed by a manager. This policy came into effect the date of the e-mail, June 7, 1995.
HYPOTHESIS 10  THE DIVISION IS PROTECTING ITS ASSETS

CCAF attribute:  11

Evaluation criteria:

10.1  important assets are safeguarded so that the Division is protected from the danger of losses that could threaten its success, credibility, continuity and existence

Conclusions

Hypothesis 10 is generally met.

Traditional organizational assets such as dollars, fixed and moveable capital items are safeguarded by corporate level policies and procedures of departments such as Treasury and Information Systems. The VR Department is responsible for assets assigned to it; these are relatively few, as VCRs generally are assigned through matrix management to other cost centres for administrative purposes.

Procedures are now in place to protect major assets purchased by the Board on behalf of VRS clients.

The personal safety, stress levels and professional development of staff are being addressed by management.

There is potential to improve the general contract under which third party services are secured, and to include, as a minimum, a three-month follow-up requirement that would assist with determining the effectiveness of services.

Research Findings and Evidence

10.1 Very little equipment is assigned to the VRS Department; most of what is used by VRC’s is assigned to the SDLs or Rehabilitation Centre where they work.

10.2 The VRS Department does buy all kinds of equipment for clients. Items purchased include such things as computers, tools, rain gear, footwear and trucks. Small items like footwear are outright ‘gifts’. If major equipment such as a truck is bought for example as part of a business start up, the Board’s Legal Department places a minimum two-year lien on it. The lien may be longer and in some cases has extended up to five years. To have a lien lifted or reduced, the client must make a request to the VR Department, which then reviews the situation with the Legal Department.

This system has been in place for the last two years and is reported to be working well. Prior to its introduction there were some problems with accountability.
10.3 The Director of VRS considers her staff to be an asset and seeks to protect them at three levels: personal safety, stress and professional development.

10.4 Personal safety: VRC’s are at some risk from clients whose benefits have been denied or terminated. In last three years, there have been two serious physical assaults of WCB VCRs, one in the office of a third party job finding club, and one at a ferry terminal. Another VRC received threats from a client, and the case went to court.

The Board is sensitive to and concerned about personal safety. There are internal safety staff and the Board provides ongoing training for staff on how to deal with hostile clients. VRCs are provided with cell phones when on the road. Home visits have decreased largely because of the risk to staff.

10.5 Stress: According to the Director, VRCs have handled the magnitude of change in different ways and some she feels are in pre-burn out or at burn out stage. She has asked her managers to be sensitive to this and to provide extra help to encourage staff to pace themselves. A session on this issue will be included in the fall VRC professional development conference. The Board also has an Employee and Family Assistance Program to help those staff who feel more comfortable addressing issues privately.

10.6 Professional development: The Director is encouraging VRCs to join the Canadian Association of Rehabilitation Professionals (CARP); her goal is to have all staff accredited. To assist, the Department pays for accreditation. At present some 60-70% of staff are accredited and about 50% are ARP’s. Some staff have declined to seek accreditation.

As noted elsewhere, the Board is also providing financial assistance and educational leave to 8 members of the Department who are enrolled in the Masters in Rehabilitation program at the University of Calgary.

10.7 While most vocational rehabilitation services are delivered by internal staff, there are contracts with some external service providers. Usage is currently at the discretion of VRCs: if a VRC feels a situation warrants external involvement, then he/she discusses the need with the manager, and upon approval makes the arrangements, which are formalized through a contract with external consultant or organization.

Third-party service providers are used for specialized services or resources. Information presented to the Commission at its hearings in March showed third party provider expenditures by type of service for 1997 as follows:
Another document presented at the same time reported that the total cost of third party referrals from Vocational Rehabilitation Services in 1997 was $1,281,026.60. The research team is unable to account for the difference between this figure and the one in the table, except to note that the first entry, for functional capacity evaluations/worksite job analysis may include some internal costs.

There is a preferred provider list, with 147 providers currently on it.

To date, the Director has not had sufficient resources to conduct an extensive analysis of the use and quality of external providers or to safeguard service suppliers as an asset. One of the recently hired managers has been assigned responsibility for this area. Her job includes to review 1997 statistics, clean up external provider work, put a 'pro forma' contract in place, and make the statement of services more outcomes focussed and less ad hoc. The intent is to include a three-month follow up as part of the contract requirement. The Department is also considering the need for contracts to contain information on protection of external suppliers.

According to the Director, the intent of this work is not to have more contracting out, but to clean up a process that has existed for a long time.

10.8 Data is also considered an asset. Effort is made to protect the Department’s major database, the RPM. For example, passwords to access the RPM on the LAN expire every 45 days.
HYPOTHESIS 11 THE DIVISION’S AFFAIRS ARE CONDUCTED IN ACCORDANCE WITH LEGISLATED REQUIREMENTS AND WITH EXPECTED STANDARDS OF CONDUCT

CCAFl attribute: 4

Evaluation criteria:

11.1 the Division is responsible for complying with legislation and related authorities
11.2 the Division is conducting its business with fairness, equity and probity
11.3 while achievement of results is important, the manner in which results are obtained is also important. The public expects the Board to be fair and ethical in the delivery of its programs

Conclusions

Hypothesis 11 is supported by the evidence.

The research did not identify any outstanding issues related to legislation and other authorities.

An external advisory council and a vocational rehabilitation-specific code of conduct may provide additional safeguards to ensure fairness, equity and probity.

As long as there is leeway allowed to VRCs to tailor the services delivered to the needs of individuals, there will be the potential for actual or perceived unfairness. One purpose of the appeal process is to provide an avenue for redress where such unfairness is proven. Additional analysis of vocational rehabilitation-related appeals may yield information that would assist managers to reduce or avoid behaviours and decisions that are not considered fair and ethical.

Research Findings and Evidence

11.1 Provision of vocational rehabilitation services related to rtw and quality of life is discretionary. There are no specific legal requirements with which the Board must comply.

11.2 The only legal concern regarding vocational rehabilitation services that the research identified is the legality of the level of Code R - Income Continuity payments. As described elsewhere, the Board has changed the basis for these payments.

11.3 The VRCs’ work relating to determining disability pensions appears to be fully in compliance with the legislation.

11.4 Related authorities identified include the policies and manuals. These are approved by the Panel of Administrators. It is a value judgement as to whether the policies and manuals provide for adequate and appropriate services and whether the right people are being referred for and accepted into vocational rehabilitation.
Compared with other jurisdictions, the services offered by the WCB of BC are as comprehensive and generous as elsewhere; it is one of the few organizations that offers assistance with business start-ups.

There is some concern that in the last couple of years the number of persons approved for rehabilitation has decreased and the length of services received has decreased i.e. workers are being forced to return to work too soon resulting in the ‘walking wounded’.

The Director of VRS expressed a concern that there may be some populations who are not receiving as much help as they might. One such group comprises high wage earners who face a lot of barriers to re-employment.

There also appears to be some concern that practice is being mixed with policy — the 1998 Rehabilitation and Compensation Services Business Plan notes an initiative to revise policy: ‘Review and update manual to separate policy from practice, in response to a variety of internal and external change requests’.

11.5 Fairness, equity and probity: As noted in Hypothesis 6, where stakeholder satisfaction is discussed, many clients are satisfied with their connections with the board. There is, however, a core of workers and employers who are not satisfied. Not surprisingly many of these are C claimants, that is, persons who have complex claims and who are more likely than other claimants to be referred for vocational rehabilitation.

The board is well aware of low levels of satisfaction among certain claimants and employers, as well as others such as referring physicians, and is attempting to improve its service levels. For example, the 1996 Strategic Plan notes that ‘the Board has a clear duty to provide timely, professional, efficient service’; it must ‘serve its stakeholders and the public interest in a sensitive, respectful and effective manner’. This ‘service challenge’ (along with other the other challenges identified in the plan) has continued to drive — on paper at least — the planning process at both the Corporate and Divisional level. In the 1998 Corporate Business Plan, for example, client service is cited as the first Rehabilitation and Compensation Services Division strategy. It is also a major driver behind larger Board initiatives such as e-file and case management.

11.6 The research sought to determine whether the percentage of appeals relating to vocational rehabilitation services and employability assessments could serve as a proxy in terms of fairness and equity. The Board, however, does not categorize appeals in this way and it is not possible to identify those appeals that relate to vocational rehabilitation.

The Director of VRS noted that she receives copies of all the important decisions on appeals with a vocational rehabilitation content. Such appeals cover a wide gamut from plans that did not go far enough, to inadequate job search allowance and denial of the purchase of a computer. While the Department does not conduct any appeal-specific analysis, for example to see if appeals are more common in certain SDL’s or from specific desks, the Director considered that few appeals arise from SDR’s; that is, most
concern cases dealt with by Area Offices. The Director does review the appeal decisions she receives and where appropriate shares this information with staff. Managers are required to read all the decisions.

11.7 The level of expenditure on services is determined on a case by case basis by the VRCs. There are no guidelines to assist VRCs to determine when enough is enough. The decision depends on a variety of factors such as age, motivation and the likelihood of job opportunities at the end of services. VRCs are controlled to some extent by limits contained in financial spending authorities; expenditures above a certain level have to be approved by managers, which adds a level of checks and balances to the system. Although the Board strives for consistency among VRCs, it is avoiding a ‘cookie cutter’ approach, so that it can better respond to the differing needs of individuals. According to the Director of VRS, it is hard to explain to a claimant who believes that he/she did not receive as much as someone else in similar circumstances why this occurred.

11.8 Lack of documentation or knowledge may constitute a lack of fairness: if people do not know their way around the board, or what their rights are, or what to expect, they may possibly not receive as many services as more knowledgeable claimants. The research did not identify any recent analysis of this; it was however raised in the 1994 Evaluation. In the group interview, VRC’s also asked the research team if they had identified any pamphlets or other hand-outs for clients. VRCs themselves are not aware of any.

11.9 In the group interview, VRC’s noted that the Board does not inform workers of their responsibilities when they receive vocational rehabilitation.

11.10 As far as we can determine, the board provides vocational rehabilitation documentation such as return to work plans, in English only.

11.11 There is no specific code of conduct for VRCs. All staff have to conform to the legislation and to the Board’s general Standards of Conduct.

The 60-70% of VRCs who hold Accredited Rehabilitation Professional or Canadian Certified Rehabilitation Counselor status adhere to a Code of Professional Ethics. Those VRCs who are registered psychologists, occupational therapists or other designated professionals also have codes of conduct and professional ethics. However, because some VRCs are not accredited or certified, the Director is considering developing a code of ethics for VRC’s. Consultation with the union would be essential.

11.12 The Vocational Rehabilitation Services Advisory Council was established in 1993 and met for the first time in April of that year. With membership from the worker, employer and vocational rehabilitation public interest, it was to act as an advisory body on matters affecting the delivery of quality vocational rehabilitation to workers in BC. It was to identify and prioritize policy and program issues for discussion and debate, and to make recommendations to the vice president, Compensation Services Division. The council’s terms of reference note:
‘Through individual and collaborative efforts of representative Advisory Council members, the broader community, the resources and mandate of the Vocational Rehabilitation Services Department and those of the WCB as a whole, we are committed to delivering equitable and consistent vocational rehabilitation to our community.’

The council has not met since late 1996. According to the Director, VRS, it is not clear whether the council is defunct and disbanded or simply waiting to be reconstituted. The vice president, RSC Division does not support the council; the director thinks it could have some merit.

At one time there was also a Vocational Rehabilitation sub-committee that advised the Board of Governors on related matters. This sub-committee also no longer exists.

It could be argued that the disappearance or non-functioning of these bodies removes one of the safeguards for ensuring equity and fairness.