APPENDIX 5

Detailed Research Findings And Evidence By Hypothesis:
Medical Services 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 partially supported by the evidence available to the researchers. There is no evidence to-date to support criterion 1.4

The mandate and mission for the Medical Services Department are documented. However, only limited specific goal/objective statements have been found. Where goals or objectives are available, they are often activity- rather than outcome-oriented. Data on the numbers and timeliness of activities are available. No client-based outcome data has been identified.

Documentation of the external and internal business environment, critical success factors and strengths/weaknesses in the Divisional Business Plans is brief for Medical Services, and could be improved in terms of internal logical consistency. They could also be improved in terms of the recognition and discussion of the challenges faced by the organization. For example, a considerable downsizing in the size of the staff complement of the Department is anticipated in relation to the changing role of the Medical Advisors. The 1998 Budget shows a 31% reduction in FTEs and a 51% reduction in net expenses over the 1997 Budget. However, planning documentation reviewed to-date does not state that any significant change in Medical Services' mission, mandate, roles, etc. was planned. The research team would have expected to see discussion of this topic and the related issues in the plans.
Research Findings and Evidence

1.1 purpose (mandate, mission, goals/objectives) are clearly stated

1.1.1 The main Medical Services mandate stems from Sections 21 — “Medical Aid”, and 56 — “Duty of physician or practitioner” of the Workers’ Compensation Act. Other sections may also apply.

1.1.2 The Orientation Manual describes sections of the Act relevant to WCB physicians. Listed as major are: 5 (1-4), 5 (5), 22, 23, 29, 30, 39 (1) (e), 56, 57, 58, 61, 89, 90, 91, 96, 99. Listed as other are: 6, 7, 16, and 21. Also listed is Schedule B. (WP309)

1.1.3 Under the Act,
• The WCB has authority to direct, supervise and control the treatment of an injured worker and to establish the fees payable for it.
• All questions as to the necessity, character and sufficiency of the health care to be furnished are to be determined by the WCB.
• Subject to the authority of the WCB to supervise and provide for the delivery of health care, the worker is allowed a free choice of the physician or other practitioner who will provide treatment.
• Section 56 of the Act sets out the duties of physicians and qualified practitioners who treat injured workers.
• Section 57 gives the WCB authority to require a worker to be examined and allows the WCB to reduce or suspend compensation if a worker declines to undergo essential treatment or performs acts which retard or imperil his or her recovery. (WP155, p. 1-2)

1.1.4 ‘Section 21(1) of the Act provides that "Health care..shall at all times be subject to the direction, supervision and control of the board" and that "all questions as to the necessity, character and sufficiency of health care to be furnished shall be determined by the board.' (WP300, p.6)

1.1.5 ‘The WCB has taken the general approach that a worker's doctor or other treating practitioner is responsible for the worker's treatment. The WCB functions as an advisor to ensure that the practitioner is aware of all the alternative available treatments.’ (WP300, p.6)

1.1.6 From Health Care Issues Under the Workers Compensation Act, A Briefing Paper. ‘The Worker's Compensation Board provides for the delivery of health care to workers with occupational injuries and diseases. Subject to some restrictions, the WCB will pay for services rendered by physicians, hospitals, various 'qualified practitioners', and other treatment and service providers. The major elements of the responsibilities in this area are as follows:
• The WCB has authority to direct, supervise and control the treatment of an injured worker and to establish the fees payable for it.
• All questions as to the necessity, character and sufficiency of the health care to be furnished are to be determined by the WCB.’ (WP155, p.1)

1.1.7 ‘Schedule B, by definition, is Board policy pursuant to Section 6(4) of the Act that establishes a presumption of a work relationship between a disease and a work process. Problems have arisen where Board medical advisors do not accept the presumption established in Schedule B. In these cases the opinion of the individual advisor that the disease is not work-related has the effect of voiding the policy of the Board. Recommendation 22: The BCFL recommends that Board policy clearly set out the role of Board officials in the adjudication of claims under Schedule B. Specifically, there should be clear direction that the relationship established by the schedule cannot be altered pursuant to claims or appeal decisions pursuant to Section 6(3).’ (From the BCFL Submission to the commission, p. 17)

1.1.8 The report Health Care Issues Under the Workers Compensation Act notes that ‘The BC Act provides that, without restricting its authority to supervise and provide for the furnishing of health care in cases where the WCB considers it expedient, the WCB ‘shall permit health care to be administered, so far as the selection of a physician or qualified practitioner is concerned, by the physician or qualified practitioner selected or employed by the injured worker. Except in certain circumstances, the WCB gives the worker unlimited choice in selecting his or her attending physician or qualified practitioner or in changing physician or practitioner during the course of treatment.’ (WP155, p.9)

1.1.9 The Briefing Paper Medical and Legal Issues Related to the Recognition of Occupational Disease notes: ‘The Board's published policy interprets the wording of this section to mean that for diseases to which section 6(1) apply, there are three basic requirements for compensability. To be entitled to benefits other than health care benefits:

• The worker must be suffering (or in the case of a deceased worker have suffered) from a disease designated or recognized by the Board as an 'occupational disease';
• The disease suffered by the worker must be or have been 'due to the nature of employment' in which the worker was employed; and
• The worker must be 'disabled from earning full wages at the work' at which he or she was employed as a result of the disease. In the case of a deceased worker, his or her death must have been caused by such disease.’ (WP154, p. 5-6)

1.1.10 The 1996 Orientation Manual for WCB Physicians contains this mission statement for Medical Services:

‘The well-being of the injured worker is our first concern.'
Continuing improvement in the quality of medical care and rehabilitation of injured worker is our challenge. Opinion which is objective, impartial, independent and in accordance with the Canadian Medical Association Code of Ethics is our commitment.’ (WP309)

1.1.11 In a presentation to the commission, Dr. Blair stated: ‘As the organization relies on external providers there is a need to effectively monitor and lead the provision of services throughout the province ... Medical services within the organization have a specific purpose in supporting effective claims management but we also see an additional and very important role to enhance quality of care and to lead the evolution to evidence based medicine.’ (WP472)

1.1.12 The OT Network Training Manual Key Policies for Occupational Diseases notes that there are seven key policy issues:

- the disease must be a designated an 'occupational disease' to be compensable,
- a disease can be designated an 'occupational disease' in four ways,
- the disease must be due to the nature of the employment,
- aggravation of an underlying or pre-existing underlying condition or disease can also be compensable,
- wage loss benefits can be paid where the worker is 'disabled from earning full wages at the work at which he was employed',
- date of injury is the date of disablement

The time limit for claiming is one year from disablement or death.’ (WP261, Sec. 3)

The research team is advised that there are conditions such as hard metal lung disease, occupational asthma and asbestosis where the diagnosis is made several years after disability that was initially believed to be non occupational in origin. In the case of hard metal disease in saw-filers where the disease was not recognized until 5 or 10 years after they died, the widows were compensated.

1.1.13 The 1996 Orientation Manual for WCB Physicians provides the following ‘Quantity goals to guide Medical Advisors: AB's [at-board examinations] 8/week, WSV's 1/week, File Reviews 40/week. Note: Many Medical Advisor activities equally important to those listed above have not been assigned to a quantity goal, e.g., liaison with Attending Physicians. Turnaround time goals to guide Medical Advisors: AB's 2 weeks, PFI's 3 weeks, Consultant Exams 3 weeks, File Reviews 2 days.’ (WP309, Sec. 5)

1.2 the program makes sense in light of the conditions to which it is intended to respond

1.2.1 The RCSD 1998 draft Business Plan confirms that the Medical Services Department has undertaken a recent analysis of the business environment. External factors considered by the Department include: a decrease in a new and ongoing level of claims, expedited
service, the Royal Commission, electronic data, less major trauma, more ASTD and stress-related claims and increasing availability of external providers of medical advice. The internal factors identified were: Departmental participation in the organization's transformational strategies such as E-file, Case Management, Continuum of Care and Clinical Practice Guidelines, the need to prepare staff and management for business changes, and the increasing use of technology. The most significant variable in the demand for medical services is the Claims Department. (WP269, p.29)

1.2.2 The continuum of care process is set out in the WCB strategic plan as part of the 'Case Management' and 'Clinical Rehabilitation' strategies for improved service delivery to injured workers.

**Case Management**
'The Case Manager...will facilitate and coordinate the involvement of other Board and external experts to deliver services including effective clinical rehabilitation...'

**Clinical Rehabilitation**
'The Act directs the WCB to supervise the care of injured workers. Protocols and guidelines for treatment will be developed with the supervising professional bodies...Systems will be developed to assist treating physicians to track their patients relative to protocols in order to assist them to provide the most timely and effective treatment to injured workers.' (WP33, p.2)

1.3 *measurable, outcome-focused targets have been established for long-term goals/objectives*

1.3.1 For the period 1995-1997, measurement of the quality and efficiency of services became a major focus for RCSD. The impact on Medical Services is not documented. The measures listed appear to be concerned with administrative efficiency more than client outcomes. Quality management appears to be concerned primarily with the equity, probity issue. (WP1, p.4)

1.3.2 The draft 1998 Business Plan for RCSD contains budgets and forecasts for the number of examinations, opinions, work site visits, and the timeliness of opinions, exams, and ratios of medical advisors to exams, opinions and work site visits. (WP269, p.33)

1.3.3 Critical Success Factors (CSFs) for Medical Services are included in the Divisional 1997 and draft 1998 Plans. (WP1, p.30, WP269, p.36)

1.3.4 The 1995 CSD Business Plan listed the Departmental key outcomes as medical examinations, medical opinions and worksite visits. In our opinion, these are utilization statistics not outcome measures.

1.4 *there is a logical, plausible link between mandate and goals/objectives*
1.4.1 The documentation reviewed did not include any models to demonstrate the logic between mandate and objectives or between objectives, activities and outcomes. There is insufficient data to comment on this criteria to-date.

1.5 goals/objectives reflect/are cognizant of the challenges the Division faces

1.5.1 As noted above, the RCSD 1998 draft Business Plan confirms that the Medical Services Department has undertaken a recent analysis of the business environment and stages the challenges it faces.

1.5.2 The Compensation Services Division 1996 Business Plan noted: ‘Developing quicker access to community treatment resources and internal medical consultation are critical to identifying and implementing case management plans. Delays in obtaining such services and programs significantly impact benefit dollars being maintained at full wage loss equivalency during waiting periods associated with treatment and/or surgery.’ (WP300, p.50)
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

The hypothesis is partially supported by the evidence available to the researchers.

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 the 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 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.
Research Findings and Evidence

2.1 intended performance is clearly established through effective planning processes

2.1.1 Rehabilitation and Compensation Services initiated strategies to support the 1996 Business Plan designed to transform the WCB. (WP1, p.13) Examples are the Case Management system and E-files.

2.1.2 The 1996 Compensation Services Business Plan presented the following strategies for Medical Services, to meet the four corporate strategic directions:

Customer Service
- To continue to improve timeliness of medical opinions and examinations in the SDL’s, particularly for Occupational Health and Disability Awards.
- Continue with the decentralization of ASTD-related medical advice to Area Offices.
- Improved access to external medical resources for pension and consultant exams.

Financial Stability
- To work with the other departments within the Compensation Services Division to reduce the 1996 administrative budget for the Medical Services Department, possibly 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 very low level of grievances.
- To provide consistent, relevant and comprehensive feedback to all members of the department relating to key operational information, particularly with regard to timeliness.

Community Confidence
- Liaison with BCMA. and UBC. (WP300, p.62)

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

2.2.1 Divisional objectives and strategies are organized into four major categories; client/customer service, financial stability, corporate leadership, community/confidence profile in Division's 1996 Business Plan (p.23). This reflects the structure laid out in the Board’s 1996 corporate Strategic Plan. (WP3, p14)

The 1997 Business plan does not directly relate to this structure. The new strategies are: Client Service, Case Management, Operational Effectiveness, and Compensation Policy and Training. The relationship between these elements is not described. (WP1, p.38) Similarly, the extracts of the draft 1998 Business Plan for the RCSD do not reflect the original four objectives listed in the organizational strategic plan. (WP269)
2.2.2 The 1996 WCB Business Plan states the organization has six primary services and products, two of which directly relate to RS: services to injured workers and rehabilitation clinic services. Key performance measures for the services and products are listed.

Services to Injured Workers measures are grouped under: claims adjudication and payments timeliness; early intervention and duration; effectiveness of vocational rehabilitation, and customer satisfaction. Measures for customer satisfaction in the client survey are overall quality of service and level of communication. The measure for early intervention is 'Retrospective' Duration. (WP328, p.13-14)

2.2.3 The Orientation Manual for WCB Physicians includes a copy of the corporate strategic plan. (WP309, Sec. 1)

2.2.4 The Rehabilitation & Compensation Division Operating Report for 1996 states: ‘Addition of a Senior Medical Advisor to Rehabilitation Centre to provide clinical direction for the programs, especially Medical Rehabilitation. Medical Services staff are active members of the Case Management Continuum of Care and Clinical Practice Guidelines project teams.’ (WP305, p.3-4)

2.3 management processes are integrated and consistently focused on key aspects of performance

2.3.1 In the 1993 Administrative Inventory the Rehabilitation Physicians complained of inflexibility in the system for scheduling clients, a lack of interest by the Board in research and resistance by the Board regarding program development and transformation. (WP252, p.38) It should, however, be noted that there have been some changes; for example, the Rehabilitation Centre is now involved in a study looking at predictors for chronic pain.

2.3.2 In 1996, ‘Members of the Medical Services Department, the Psychology Department, and the Rehabilitation Centre have been developing a "Care Map" that should integrate existing services within and outside the Board.’ (WP300, p.61)

2.3.3 The Rehabilitation & Compensation Division 1996 Operating Report stated: ‘Establish clinical practice protocols and evidence-based practice for rehabilitation. Work with Medical Services in the development of case management protocols utilizing published research and internal program evaluation. All Medical Services protocols are fully consistent with the Rehabilitation Centre's continuum of care.’ (WP305, p.23)

2.3.4 The 1997 RCSD Business Plan notes that Medical Services is involved in project teams for Case Management, E-files, Clinical Practice Guidelines, and Continuum of Care. These initiatives ensure medical staff have input and it provides them with an opportunity for ‘learning, skill development, and service improvements’. (WP1, p.30)
2.3.5 The 1998 RCSD Business Plan notes that Medical Services doctors are participating in a number of strategies to transform the Board: E-files, case management, continuum of care, clinical practice guidelines and Disability Awards assessment (ARCON). (WP269, p.35)

2.3.6 1997 Minutes of the WCB Medical Advisory Committee Minutes. “Discussion followed on ways of addressing the physician community on our budget and that we support this initiative. Dr. Naismith will work with Dr. Tomson to ensure Medical Rehabilitation fits into this model.” (WP313)

2.4 the focus at all levels is on intended and actual performance

2.4.1 In the first quarter of 1995, the Medical Services Department reported that the Clinical Practice Guidelines (CPGs) for Low Back Pain were adopted and the Standardized Medical Assessments for Low Back Pain was ready to be piloted in Coquitlam and Abbotsford. (p. 6, WP9) The CPGs for Low Back were published in October 1995. (WP310)

2.4.2 The Compensation Services Division Performance Report for the 3rd Q 1996 states: To establish clinical practice protocols and evidence-based practice for rehabilitation Medical Services is working in an on-going way with others to develop case management protocols utilizing published research and internal program evaluation. (WP15, p.16)

2.4.3 The characteristics of a good medical opinion are described in Section 2 of the Operation Manual. (WP309)

2.4.4 The Procedures Manual for Physicians include descriptions of medical and client service procedures, e.g., clinical referrals, medical examinations procedures, medical negligence for malpractice, refusal of exam and disability benefits. (WP311, Sec. 4, 5)

2.4.5 The Attending Physician's Handbook discusses the Board's expectations regarding reporting and confidential information. (pp. 9 and 13) It also includes standardized assessment forms for patients with low back pain and for patients with cervical pain. (Appendix) Also included are clinical practice guidelines for low back pain, neck (cervical) pain, meniscal tears, carpal tunnel syndrome and epicondylitis. (pp. 15-33)

2.4.6 The Service Delivery Project "is designed to improve the quality, value, and level of service provided to clients of the WCB. It includes a business process reengineering initiative, an electronic claim file (e-file) plan, changes in medical payment processing and reporting, an initiative to simplify and expedite the reporting process for injured workers (referred to as Form 14, since it combines old forms 6 and 8), a new performance management system, and the designation of one of the SDLs (Coquitlam) as a model office for the trial and evaluation of new work methods and technologies." (WP18, p.20)

2.5 objectives and plans are tailored to meet the mandate within resource allocations
2.5.1 In the first quarter of 1995, a work group of Medical and Compensation staff reviewed the utilization of medical staff resources and recommended changes planned for implementation in the second quarter of 1995. (WP9, p.6)

2.5.2 The 1996 Business Plan strategy "focus on fundamentals disability awards" is designed to improve processing times, improve consistency of file management, clarify roles, increase productivity etc. It includes among other components working with Medical Services to develop PFI examinations at the time the worker is assessed at the Board (AB) at the time of "plateau"/recovery. The change for the worker is supposed to be improved customer service as they will not have two medical examinations in many cases. (WP300, p.A29)

2.5.3 In June 1995, "the Process Improvements Group completed their report. This was presented to all Lower Mainland SDL's. The Area Office SDL's will receive it early in 1996. The goal is to redefine the role of the Medical Advisor. If successful, medical opinions not based upon a physical examination will decrease while examinations will increase." (WP300, p.61)

2.6 adequate funds and staffing are dedicated to the process to ensure success

2.6.1 "With a staff complement of 72 persons (about 45 doctors) and a budget of $7.8 million, the Department conducted 12,661 medical exams in 1994 and produced a total of over 60,000 medical opinions. The physician is frequently the dominant force in determining compensability in complex cases, but medical judgements are subject to review by Medical Review Panels, the Appeal Division, and the Workers' Compensation Review Board." (WP18, p.37)

2.6.2 In 1996, "Medical Services timeliness of opinions and productivity by each Advisor is expected to remain constant with recent experience." (WP300, p.70)

2.6.3 The Summary of Administrative Operating Expenses 1995-1998 shows a significant decrease in staffing levels for 1998 compared to previous years. Explanation of the decreases in the 1998 Budget are not documented. (WP301, p.6)
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2.6.4 The 1998 Budget FTEs include 6.00 Medical Administration and 6.33 Medical Clerical staff FTES. The remaining FTEs are professional staffing, e.g., DAMAs, Medical Consultants, Medical Advisors, and ODS Medical Services.

2.6.5 The draft 1998 Business Plan is based on the assumption that increased emphasis on early intervention and continuum of care will result in the need for fewer physical examinations and file reviews. (WP269, p.36)

2.6.6 In an interview, the Director, Medical Services noted that the Board has implemented a retirement policy; six or seven Board Medical Advisors are over 65 years of age; of these, six (approximately 10%) will be retiring and will not be replaced. Their work will be picked up by staff currently involved in PFI work. PFI measurement, in turn, will be contracted to an outside firm to address ‘charges’ of possible conflict of interest and lack of objectivity. In addition, Disability Awards is making process improvements to get more timely and accurate decision; this reduces the need for three to four Medical Advisors. (WP434, p.2)

2.6.7 In a presentation to the commission on March 2, 1998, the Director, Medical Services discussed staffing levels. There are about 50 physicians at the Board. About 20 are rehabilitation physicians supporting programs (e.g. the Centre, prevention, occupational disease). In addition to these staff, the goal is to have one medical advisor and one nurse advisor for each service delivery location (i.e. 17 of each). That would reduce the medical staff from 50 to 37 by the time the plan is rolled out.
2.6.8 Two Medical Advisors will be on site for the North Vancouver case management pilot, but not in Prince George. One of the Medical Advisors will transfer to North Vancouver for the pilot project only. The Medical Advisors will participate in segments of the Case Manager training. They will have an organizational relationship to the Regional/Operations Manager. (WP 56, p.12-15)

2.6.9 The increasing availability of external providers of medical advice is expected to reduce queues for specialist service. This is factored in the budget for internal specialists. (WP1, p.29)

2.6.10 In his presentation to the commission, the Director, Medical Services noted that "Most of the private providers are employing sessional physicians from the community to give advice and expertise with respect to the clinical care plan. So you have a whole variety of information from the various treatment regimes so I don't see a need for medical advisors to be involved in most of these claims. That is why we are downsizing the number of physicians who work in the claims area. We still have many physicians in the rehabilitation centre who are associated with the delivery of rehabilitation. They will stay there because as a member of a CARF accredited program you must have physicians available. If it does go to appeal or if an adjudicator needs to make a decision you weigh the evidence of the work conditioning provider, occupational rehabilitation provider, the pain program provider and the physician." (WP472)

2.6.11 The Second Quarter 1997 Operating Report notes that "The Visiting Specialists Clinic was initiated with approximately 10 specialists hired to provide diagnosis and further medical management guidance."

2.6.12 In his presentation to the Commission, the Director Medical Services explained that the visiting specialists program was “set up to bring together a select group of highly qualified specialists, often sub-specialists in certain fields particularly in orthopaedics together. A small clinic is set up in the building and these specialists are brought in for ½a day or a day, a week or every second week or once a month to see certain kinds of cases that are having trouble getting seen elsewhere for various reasons. One is individuals where the subspecialty is in short supply and there are parts of the province where ready access doesn't seem to be happening. Some situations may have attending physicians and referring consultants from the periphery seeking another opinion from a higher level specialist. So there is a whole variety of situations where there is a need for highly specialized expertise in a fairly expeditious timely way.” (WP472)

2.6.13 The Rehabilitation & Compensation Division Operating Report for 1996 notes: "During 1996, the inventory of outstanding Permanent Functional Impairment examinations was assessed in each office and resources were deployed to reduce the queue. This resulted in an improvement of 17% in the timeliness of these exams." (WP305, p.6)

2.6.14 At the commission hearings, Medical Services Director commented on the role of Nurse Advisors: there are currently 50 Medical Advisors. The Board expects to reduce this
number by 13 to 37, at the same time adding 20 Nurse Advisors. The 37 MAs will include: 17 MAs associated with claims administration (they are aiming for 1 MA and 1 NA per SDL or AO) plus 20 MAs in the Rehabilitation Centre, Prevention, Occupational Diseases, etc. The NA's will provide advice on 'simple' issues and interpretations." (WP484, p.1)

2.6.15 From WCB Medical Advisory Committee, Terms of Reference 1997. "Because of problems with the productivity/timeliness and consistency in the Occupational Health Department, it has been suggested that the Board would benefit from the rotation of Medical Advisors through this department. It is the understanding of the Occupational Health Physicians that there are plans to distribute the ASTD claims to the Area Offices in the relatively near future. This may serve to alleviate the problem." (WP313)

2.7 the plans clearly communicate the standards of service clients (workers, employers) should expect when accessing rehabilitation programs

2.7.1 Standards, definitions etc. are documented in a variety of sources. For example:

- The Permanent Functional Impairment Outline was revised in August 1995. It included discussion of: assessment of functional impairment, nervous system, vision, hearing, upper extremities, hand, lower extremities, spine and pelvis, and devaluation, enhancement, and age adaptability.

- The Attending Physician' Handbook includes standardized assessment forms for patients with low back pain and for patients with cervical pain. (Appendix) Also included are clinical practice guidelines for low back pain, neck (cervical) pain, meniscal tears, carpal tunnel syndrome and epicondylitis. (pp. 15-33)

- The Attending Physician's Handbook discusses the Board's expectations regarding reporting and confidential information. (pp. 9 and 13)

- The Board’s October 1995 Clinical Practice Guidelines for Diagnosis & Treatment of Low Back Pain Guidelines discuss medical assessment, medical management, investigations, education and a variety of treatment modalities.

- The 1992 Permanent Disability Evaluation Schedule lists conditions an injured worker might experience with the percentage of total disability that can be assigned. Included are: amputations, immobility, shortening, denervation, impairment of vision, impairment of hearing, compression fractures, and loss of range of motions.

- "Clinical Practice Guidelines (CPGs) are developed based on research on medical outcomes. These guidelines included "point of service guidelines" that tell us what interventions are needed. They also include "longitudinal guidelines" that tell us
when these interventions should occur. The Medical Services Department and Rehabilitation Division are currently reviewing CPGs that have been developed by both Canadian and U.S. agencies with the intent of adapting these to local conditions. The endorsement of professional associations will then be obtained...Once ratified by the BCMA, these guidelines will be published and shared with the major stakeholders including employer and union representatives, Review Boards, Appeal Division, community physicians and other health care providers.” (WP324, p.16)

- The Procedures Manual for Physicians include descriptions of medical and client service procedures, e.g., clinical referrals, medical examinations procedures, medical negligence for malpractice, refusal of exam and disability benefits. (WP311, Sec. 4, 5)

2.7.2 There is evidence that (some of) these documents are communicated internally. For example, an update to the PFI Outline (1995 version) was circulated in January 1997 to the DAMAs.

2.7.3 In response to a question regarding Board activities to educate the medical profession on some of its strategies regarding the continuum of care and work conditioning, the Director, Medical Services noted:

“In terms of the work conditioning program whenever there is a contact made there is actually information that goes with that message about the work conditioning program and supporting summary information on why it is used, how it is set up and sort of back ground information. We are also putting together more educational and informative pieces that are more broadcasted, for instance in the medical journals and some of the larger publications in the province. We are trying to raise the level of awareness around the continuum, around case management as we get there and around the various other parts of it. Another bit of that is the opportunity we have with the fee agreement process. As we develop, from time to time, differing fees or different approaches – even our whole message around exchange of information, which really arises out of the fee agreement – is an opportunity to educate the provider. I can't refer to a single fixed communication plan sometime in the past but it is perhaps more of an ongoing effort.” (WP472)

2.7.4 Not all parties are satisfied with the current level of communications. Two submissions to the commission provide examples.

2.7.5 The BCFL noted: “Functional pensions are authorized pursuant to Section 23(1) of the Act. Awards can be scheduled, in which case the percentages are listed in the "meat chart" that is Appendix 4 of the Manual. Non-scheduled awards are calculated by using the AMA Guidelines or on a "judgement basis".
Schedules are intended to reflect the average loss of earnings that will result from a specific impairment, and the Board has adopted its own unique schedules for this purpose. There are several problems with this system of scheduled awards...

Recommendation 28: The BCFL recommends that Section 23 of the Act be amended to provide for a periodic review and updating of the schedules, and require the Board to provide an explanation of why certain percentages result in certain percentage impairments. Further, Board policy with respect to the measurement of spinal impairment should provide a detailed description of how percentages are arrived at, so workers, their doctors and others can understand how pensions are calculated.”

2.7.6 The BCMA submission noted: "The BCMA continues to believe that the BCMA/WCB Liaison Committee is an appropriate vehicle for communication between the organizations. The Liaison Committee provides the WCB with an opportunity for input from the medical profession on its policy initiatives. The committee provides both the BCMA and WCB with feedback on the impact of policy on patients and physicians. The Committee is a congenial forum for discussing patient-care and administrative issues. Physicians feel that the committee functions well, and is successful at identifying opportunities and issues encountered by physicians working with the WCB. However, the BCMA is concerned that the WCB representatives are unable to influence change within the WCB. This sentiment has been acknowledged by WCB representatives. In order for this committee to be an effective change vehicle, the WCB must address issues which are identified at this committee." (I-EMA-064, p.24)

2.7.7 The BCMA submission recommended:

16) That the WCB immediately review its current policy and procedures for handling physician inquiries. This review should include an examination of current telephone contact numbers to ensure that physician inquiries are responded to effectively and expeditiously at the local or regional level. This review should included direct input from the BCMA.
17) That upon request, a physician should be able to discuss patient care issues directly with a WCB physician within a reasonable time period.
18) That if WCB staff cannot immediately answer a physician inquiry, they record the details and return the physician's phone call with the answer within a reasonable timeframe.
19) That the WCB establish a records system for physician telephone inquiries.
20) That the WCB ensure an effective framework for communicating policies/procedures to practising physicians on a regular and timely basis." (I-EMA-064, p.26)

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
2.8.1 While the documentation provided did not include any logic models to demonstrate plausible relationships between the major components of Medical Services, several initiatives support the criterion. These include clinical practice guidelines, case management, and the continuum of care. These are discussed in greater detail in the Overall Rehabilitation section. The visiting specialists program, which is described above, also supports the criterion.

2.8.2 The following table, which is extracted from the 1996 Compensation Services Business Plan also suggests a plausible logical relationship between initiative and intended impact. (WP 300, p64)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Impact</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continual improvement of timeliness of medical opinions and examinations.</td>
<td>Adjudicative staff will have information on which to base decisions in a more timely manner.</td>
<td>Throughout 1996</td>
</tr>
<tr>
<td>Decentralization of ASTD-related advice to Area Offices.</td>
<td>Injured workers will increasingly be served locally and in a more timely fashion.</td>
<td>First half of 1996.</td>
</tr>
<tr>
<td>Improved access to external medical resources.</td>
<td>Improved timeliness for PFI and specialist exams.</td>
<td>Throughout 1996</td>
</tr>
<tr>
<td>1996 Budget Reduction</td>
<td>Reduce administration budget by up to $500,000</td>
<td>Dec. 1995/Jan. 1996</td>
</tr>
<tr>
<td>Maintain positive work environment.</td>
<td>Continued low level of grievances.</td>
<td>Throughout 1996</td>
</tr>
<tr>
<td>Improved sharing of performance information with staff on a regular basis.</td>
<td>Improved performance.</td>
<td>Throughout 1996</td>
</tr>
<tr>
<td>BCMA Liaison</td>
<td>Improved cooperation with the physician community.</td>
<td>Throughout 1996</td>
</tr>
<tr>
<td>UBC Liaison</td>
<td>Improved training of undergraduate medical students in occupational health issues.</td>
<td>Throughout 1996</td>
</tr>
</tbody>
</table>
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

The evidence for this hypothesis is mixed. It is not possible to conclude that Hypothesis 3 is
adequately supported.

The structure of the Medical Services Department 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 introduction of the Nurse Advisors appears to fit within the Board’s structure and
proposed direction, and the definition of the role is relatively clear in theory, it is anticipated that
there will be a period of transition.

Who is part of Medical Services, and for what functions? Even the Director seems to have some
questions regarding this. 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 Medical
Services 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.

Three additional groups of physicians at the Board are mentioned in the evidence. There are two
Occupational Disease staff who provide centralized expertise for occupational disease claims.
These physicians may be considered part of the disability awards component but reporting of
activities does not always make that clear. There are two physicians located in Prevention dealing
with occupational health issues. The Prevention physicians have contact with MS regarding
medical content, although one document said these physicians were "aligned" under MS in 1995.
Finally, there are rehabilitation physicians who work as part of the interdisciplinary teams at the
Rehabilitation Centre.
It is possible in health care situations to create a matrix organization where clinical staff report to one person for clinical supervision and direction, and to another for administrative purposes. From the documentation reviewed, we were unable to determine how the rehabilitation physicians are managed, how their work is planned for, and how it is evaluated.

Research Findings and Evidence

3.1 rationale for current structure makes sense

3.1.1 The 1996 Administrative Inventory noted that "Before 1994, the Medical Services Department was a separate division, reporting directly to the President/CEO. In 1994, it was reorganized to align its mission more closely with the Compensation Services Division. A small client satisfaction survey was conducted in 1994 (123 respondents) to gather feedback from Medical Services Department clients. The survey indicates that client/respondents were comfortable with the structure and conduct of their examination." (WP18, p.37)

3.1.2 In the second quarter of 1996, Medical Services, Psychology and the Rehabilitation Centre were formed into the new Rehabilitation Division, reporting to the same vice president as Compensation Services Division. "The new structure combines the Vocational, Clinical Rehabilitation, and Medical Services functions to compliment the programs and initiatives being undertaken by those groups such as the focus on early intervention, disability management, the continuum of care, clinical practice protocols and Case Management. The policy, Finance and systems areas will now support both operational areas." (WP14, p.2)

3.1.3 The 1996 Compensation Services organization chart shows the Director of Medical Services reporting to the Vice President of Compensation Services. Under the Medical Director are two Senior Medical Advisors, the Senior Disability Awards Medical Adviser, and Medical Support. (WP18, p.52)

3.1.4 In correspondence with the commission, the Board notes that Medical Advisors can be viewed as providing service in four general categories:

- Disability Awards Medical Advisors: includes ‘a central group in Richmond who, on a full-time basis, provide advice to the Disability Awards Department with regard to impairment largely through the examination of injured workers. Additionally, and increasingly, Area Office and Service Delivery Location Medical Advisors are undergoing training and providing this service. A pilot is also underway to have external providers provide this service. Generally speaking, the DAMA’s perform their role in a hierarchical environment."
• SDL, AO and ODS Medical Advisors: ‘these advisors are increasingly working in a ‘team environment along with nurse advisors, vocational rehabilitation consultants, case managers and psychologists.’

• Specialists: ‘provide advice through a review of files and examination of patients to the medical advisors of the WCB. These specialists primarily provide service in a hierarchical environment.’

• Rehabilitation Centre Physicians: they ‘work in a team environment providing medical services to the various Rehabilitation Centre programs’.

3.1.5 In 1996, Medical Services also assumed supervision of the X-ray Department "which provides radiological services including films and reports and expert opinions by radiologists on difficult issues." (WP16, p.34)

3.1.6 In an Interview, the Director, Medical Services noted that there are currently two Occupational Disease Physicians housed in Disability Awards and reporting to the manager of Disability Awards. He is not is not sure if these two are on Medical Services staff complement or not. There are two physicians in Prevention who are not part of his budget, but who are included in Medical Services for professional purposes. (WP434, p.4)

3.1.7 The draft 1998 Business Plan is based on the assumption that increased emphasis on early intervention and continuum of care will result in the need for fewer physical examinations and file reviews. (WP269, p.36)

3.1.8 This was confirmed in an interview with the Director, Medical Services. When he first came to the Board (1997), the amount of clinical involvement in a claim was very little and very late, starting probably 10 to 16 weeks into the claim. Adjudicators relied heavily on the attending physicians. This is now changing, both with case management and with a parallel change in the traditional model, so that Medical Advisors become involved much earlier. Medical Advisors have become involved in facilitating with adjudicators to give clinical input as early as necessary e.g. around diagnosis, adjudication, liaison role with attending physician or consultants. In the traditional model, the decision of when to include a Medical Advisor was left to the adjudicator depending on the nature and complexity of the issue. The new approach has required some training of adjudicators and has also involved the identification of the role of Nurse Advisor. (WP434, p.2)

3.1.9 The position of Nurse Advisor was introduced in 1997. When asked at a hearing of the commission whether the main motivation in replacing medical advisors with nurse advisors is an economic one, the Director Medical Services responded:

“I wouldn't see that as a primary motivation. I would rather see it as augmentation rather than replacement. A significant part of the old role of the medical advisors would not be suitable for the nurse advisors in today's world. I think that a significant amount of the
clinical information that we need, which in the past didn't exist at all, can be provided by nurse advisors as sort of a more front line availability to the claims staff.

“The primary driver is not financial. The driver is that if we move to a model that is less forensic in nature and more holistic then we don't need as many medical advisors giving opinions on every file that comes into the organization. The whole strategy is based on relying on the attending physician to do the right thing and providing the attending physician to work collaboratively at an early stage. So it is not financially driven. In other jurisdictions that we have looked at nurse advisors have very adequately filled the niche in terms of delivering advice on the delivery of rehabilitation services – Alberta and Ontario for example." (WP472)

3.1.10 The Nurse Advisor job description was approved February 12, 1997. It sets out clearly the function, responsibilities, relationships and qualifications. Under relationships, it notes that ‘the Nurse Advisor reports administratively to a Compensation Services Manager and professionally to the Director, Medical Services for fulfilment of their responsibilities. The position works closely with the medical advisor, adjudication staff, vocational rehabilitation consultant, psychologist and other staff involved in case management. The position does not provide work direction to others.’

The Nurse Advisor role is not shown on the Medical Service organization chart dated March 3, 1998.

3.1.11 The use of external providers and sessional physicians from the community to give advice and expertise with respect to the clinical care plan, as described elsewhere in this report, permits the Board to reduce the number of physicians working in the claims area. As the Director noted in his presentation to the commission: “We still have many physicians in the rehabilitation centre who are associated with the delivery of rehabilitation. They will stay there because as a member of a CARF accredited program you must have physicians available. If it does go to appeal or if an adjudicator needs to make a decision you weigh the evidence of the work conditioning provider, occupational rehabilitation provider, the pain program provider and the physician.” (WP472)

3.1.12 In an interview, the Vice President RCSD noted that he is often asked why the Board, which is essentially an insurance company, retains staff to address entitlement to funding. His response is: “Unless there are appropriate controls in place to control outsiders, it could bankrupt the system: this is what was beginning to happen with CPP.” (WP498, p6)

3.1.13 In May 1994, the Medical Advisory Committee was formed in response to a recommendation made in the Fulton Report of May 1993. The Fulton Report states 'Physicians should be afforded the opportunity of a medical or professional advisory committee, to bring their professional issues forward to senior management.’ Doctors representing areas within the Board met with senior management and drew up Terms of Reference. These terms were approved by the Senior Executive Committee. (WP313)
3.1.14 This WCB Medical Advisory Committee noted in its Minutes:"The Doctors in the Rehabilitation Department of the WCB lack medical leadership. This leads to a reduction in their effectiveness in the rehabilitation process and the lowering of morale. An example of this problem in the situation where they are asked for medical input without having the benefit of the worker's complete file. The Physicians are sometimes given pieces of information only. Without the benefit of the complete file, their ability to assess the worker as a whole and to offer valid medical opinions is severely compromised. It is felt that if a Physician was appointed at the Manager or Director level the Rehabilitation Doctors would be able to function more efficiently." (WP313)

3.2 roles and responsibilities are clear and well-integrated

3.2.1 In a presentation to the Commission, the Director, Medical Services noted that within WCB, his Department has “a specific purpose in supporting effective claims management but we also see an additional and very important role to enhance quality of care and to lead the evolution to evidence based medicine.” (WP472)

3.2.2 There are very few job types in Medical Services: most staff are Medical Advisors (physicians). Last year the position of Nurse Advisor was introduced. In recent years, the Board has supported the use of external providers to deliver services closer to home.

3.2.3 The role of the Medical Advisor has occupied the Board for some time.

3.2.4 In a 1993 Address to the WCB Medical Advisers Meeting, J. Dorsey, then Chairman of the Board of Governors, noted that the role of doctors is blurry and can cause confusion. No one argues that replacing them with those of other doctors as was tried in Quebec will improve the system. "Board doctors may need to consider their role in assuring the future health of the injured worker. Other issues, such as literacy, training, addiction and personality problems require the attention and interest of Board doctors. The appropriate role for doctors in these issues is a matter for discussion." (WP214, p.3, 6)

3.2.5 Efforts to revise the Medical Advisor role have been underway since at least 1995, when "the Process Improvements Group completed their report in June... The goal is to redefine the role of the Medical Advisor. If successful, medical opinions not based upon a physical examination will decrease while examinations will increase." (WP300, p.61)

3.2.6 The process was still underway In 1997, when the Vice President RCSD told the commission: "We want to redefine the role for our medical advisor. Our medical advisors were trying to be of assistance to the process, however many times they were put in a very confrontational and adversarial role with respect to the worker's treating physician. We see them getting out of the case closure role and becoming more of a consultant to both the treating general practitioner and to the workplace. So we see them moving out of the board office environment where they are seeing people for examinations that result in case closure, and moving into the workplace with that case management team, being of assistance to the worker, the employer and the worker's practitioner." (WP25, p.68)
3.2.7 The CMA's 1997 policy summary of physicians' role in return to work included:

"Prolonged absence from one's normal roles, including absence from the workplace, is detrimental to a person's mental, physical and social well-being. Physicians should therefore encourage a patient's return to function and work as soon as possible after an illness or injury, provided that return to work does not endanger the patient, his or her co-workers or society. A safe and timely return to work benefits the patient and his or her family by enhancing recovery and reducing disability. Through improvement of health outcomes, a safe and timely return to work also preserves a skilled and stable workforce for employers and society and reduces demands on health and social services as well as on disability plans. The role of physicians is to incorporate a timely return to work into the care plan for their patients. The treatment or care plan should be evidence-based, when possible, and should identify the best sequence and timing of intervention for the patient...Successful return to work involves primarily the employee and his or her employer and requires the assistance of the attending physician." (WP131, p.1-2)

3.2.8 In an interview, the Director, Medical Services noted that In the past, the medical role was limited to the late stage of claims, and for 10 to 20 years, the Board probably has not had the right people in right kinds of posts. When he arrived at the Board (in 1997), Medical Services seemed archaic, with no support policy, practice service guidelines etc. He has the notion that Medical Services has only recently capitalized on some of the opportunities open to it and in the past did not contribute to the organization as well as it could have. In part this was due to the nature of the people; it was also due to the Board’s hiring process and salary scales. This has shifted in the early 90's with a wave of new younger people, who are “more current, more activist, with more to contribute and more willing to contribute.” (WP434, p.3-4)

3.2.9 In an interview, the Director, Medical Services in 1998 noted that he has revised the Medical Advisor job description. It appears this was completed in December 1997. He also stated that Medical Services is in a transition period, with this change and the introduction of the Nurse Advisor. “There is probably a fair degree of scatter regarding how much an adjudicator uses a Medical Advisor compared with a Nurse Advisor ... and some discrepancy among Medical Advisors, some of whom have been many years in the old role. So there are change issues on both sides. For Medical Advisors this represents expansion of their services and potentially expansion of influence. But there is still a gap between practice and theory." (WP434, p.1-3)

3.2.10 This statement confirms the 1998 RCSD draft Business Plan, which identified an opportunity for Medical Services as "increased flexibility to deal with changing demands through broadening the skill sets of Medical Advisors and redefining their role.” (WP269, p.36)

3.2.11 In a 1997 article in the BCMAJ, a Senior Medical Advisor in the WCB Medical Services Department was quoted as saying: "The entire organization is moving toward a more user-friendly, accountable, responsible, client-focused organization. The role of our WCB
Medical Advisors has changed from that of a claims advisory service to a resource for practising physicians treating inured workers in BC. "We are an ally for providing the best treatment for the patient." (p.632)

3.2.12 Specific duties were spelled out in a number of documents prior to the revision of the Medical Advisor role; for example:

- those of the Rehabilitation Centre doctors are clearly laid out in the 1993 Administrative Inventory. (WP 252, p.40) Additional descriptions of roles and responsibilities are laid out in the Orientation Manual for WCB Physicians dated April 1994 (WP309:Tutorial 1)

- Descriptions of roles and responsibilities for WCB physicians are laid out in the Orientation Manual for WCB Physicians dated April 1994 (WP309:Tutorial 1)

- Section 1 of the 1996 Orientation Manual for WCB Physicians includes a description of the roles and responsibilities of the medical advisor, as well as the responsibilities of the Disability Awards Medical Advisor (DAMA), the Medical Advisor, and the Health Care Benefits. (WP309)

- The WCB’s Attending Physician's Handbook (draft, April 1997) presents information about the role and responsibilities of the attending physician. (WP318)

- The June 1997 Procedures Manual for Physicians includes descriptions of medical and client service procedures, e.g., clinical referrals, medical examinations procedures, medical negligence for malpractice, refusal of exam and disability benefits. (WP311, Sec. 4,5)

- The Manual also notes: "It should be noted that whereas the Board has the right to withhold authorization for surgery under Section 21(6) of the Act, the client has the right to elect to have this surgery, regardless of authorization, if s/he is convinced that this will be of benefit, providing this is not 'clearly unreasonable'. This means that the client has the ultimate responsibility for his/her own decision-making. The medical advisor has the responsibility to see that the client has access to the best possible medical advice before making this decision." (WP311, Sec.5)

3.2.13 The RCSD 1998 draft Business Plan states "...it is expected that the skills sets of Medical Advisors will be expanded to included Permanent Functional Impairment advice to the Disability Awards Department [the research team note that this may contradict a suggestion made below regarding a pilot to determine the feasibility of contracting these services out]. The Medical Services Department will work closely with Disability Awards and others to improve the system for providing advice on disability." (WP269, p.36)
3.2.14 The BCMA Submission to the Commission notes that "Two negotiated agreements exist between the BCMA and the WCB: one for fee-for-service physicians and one for salaried physicians. These agreements are the foundation of the relationship between the WCB and the physicians of British Columbia. The BCMA is recognized by the WCB as the official representative of its members under section 2 of the current agreements." (I-EMA-064, p.5)

3.2.15 In a 1998 presentation to Executive Committee, the Vice President RCSD stated: "An important amendment to the preamble whereby physicians acknowledge their role in physical rehabilitation and assisting the WCB in returning injured workers to employment. Physicians have agreed to promote the value of safe and timely return to work with WCB patients. This acknowledgement is an important development in the relationship between the WCB/BCMA and will assist in the co-development of clinical practice guidelines and care plans for the treatment and return to work of injured WCB clients." (p.1)

3.2.16 Despite all these statements, the BCFL, as noted above, contends that there have been situations in which Board medical advisors do not accept the presumption established in Schedule B. In these cases the opinion of the individual advisor that the disease is not work-related has the effect of voiding the policy of the Board. The BCFL recommends that Board policy clearly set out the role of Board officials in the adjudication of claims under Schedule B. Specifically, there should be clear direction that the relationship established by the schedule cannot be altered pursuant to claims or appeal decisions pursuant to Section 6(3). (BCFL Submission to the commission, p.17)

3.2.17 In an interview, the Director, Medical Services confirmed that the Board, in the summer 1997 introduced the position of Nurse Advisor, “parallel to the Medical Advisor”. “These hires balance off those physicians retiring.” The intent is to have 1 Nurse Advisor for each area office (except Abbotsford) that provides full service claims management, prevention, and safety officers, and 1 Nurse Advisor for each SDL for claims management aspects only. “Nurse Advisors seem to be well accepted. [The research team suggest it may be too early too tell.] This is a brand new role; we are still defining the role because there are no role models or mentors.” Initially 4 Nurse Advisors were hired in the fall of 1997 for SDL’s; two more have been added since. One Nurse Advisor is attached to the Prince George case management prototype, to develop the role of Nurse Advisor in the case management model." (WP434, p.2)

3.2.18 A draft WCB practice directive compares Nurse Advisor Referrals with direct Medical Advisor Referrals.

“The Nurse Advisor generally acts as the first avenue of contact with officer level staff re written and/or verbal medical questions/concerns. The Nurse Advisor will seek direction or advice from the Medical Advisor on these referrals as required. A list of items that should be referred directly to a Medical Advisor is attached. The following are those items which a Nurse Advisor will generally handle, without assistance from a Medical Advisor.
• Routine questions of relationship of diagnosis to injury/incident - including reopenings.
• Assistance in the development of care plans (recovery/RTW dates).
• Interpretation of medical information to non-medical staff.
• Routine contact with attending physicians or other qualified practitioners who are reluctant to refer to Continuum of Care programs (i.e. external provider liaison).
• Identification of missing medical/clinical information/documentation.
• Liaison with various Health Care Providers to expedite referrals/appointments as necessary.
• Liaison with Occupational Health Nurse/delegate at place of employment re RTW as requested.
• Requests for extension of chiro, physio & naturopathy RX in conjunction with the adjudicator.
• Health care benefit questions.
• VRC’s inquiries concerning home support.

VRC’s inquiries concerning home support.”

No mention is made of the responsibility for contacting claimants for more information.

“Direct Medical Advisor Referrals

The following are appropriate direct referrals to Medical Advisors. All other questions will be handled by the Nurse Advisor. The Nurse Advisor will seek direction or advice from the Medical Advisor as required.

1. Attending physician requests Medical Advisor input.
2. Surgery approval where it is not readily evident to the adjudicator.
3. Diagnostic testing requests, Visiting Specialist Clinic referral requests from outside MD.
4. Where there are complex medical issues or issues which will likely be highly contentious. These include:
   • cases where there is an apparent inconsistency regarding the medical diagnosis and the reported mechanism of injury.
   • cases where there are multiple diagnosis on file or where non-compensable conditions are a significant factor in causation." (WP152)

3.2.19 There appears to be some concern among the medical community regarding this new position. In its submission to the Commission, the BCMA recommended that:

28) The WCB provide full disclosure of the process used to develop the role and functions of the current nurse advisors employed at the WCB.
29) The WCB initiate a review of the position of nurse advisors, and that the BCMA provide formal input into the review process.
30) The WCB disclose the full job description and authority granted to Nurse Advisors.
31) The BCMA be allowed to provide formal input into the process for establishing WCB Nurse Advisors.
32) The final decision regarding patient care continues to rest with the attending physician.
33) All recommendations of a Nurse Advisor regarding a patient are officially communicated to the attending physician." (I-EMA-064, p.33)

3.2.20 In a 1997 meeting of the Medical Advisory Committee, the Vice President RCSD addressed comments regarding the anxiety of the Board physician community. He "reinforced the fact that this is a transitional time and during this phase there will be realignment of physicians, but other than attrition, there will be no loss of jobs. This change will not diminish the role of the physician, but enhance it. There will be a balance of roles between the Medical Advisor and Nurse Advisor." (WP313)

3.2.21 With respect to external providers, the Board’s Policy Priorities 1998 notes that Compensation Services would like to do a pilot project using external providers to assess PFI using ARCON under the supervision of a physician. Current policies indicate that with few exceptions Board medical staff have the responsibility for PFI examinations. The Panel has requested that the Policy Bureau maintain involvement with the project and consult with stakeholders on the outcome. (WP114, p.8)

3.2.22 The Director, Medical Services in a presentation to the commission, noted that “As the organization relies on external providers there is a need to effectively monitor and lead the provision of services throughout the province.” (WP472)

3.2.23 Case Management introduces other changes in roles and responsibilities. The 1996 RCSD Business Plan notes: "Traditionally there are hand-offs from area to area as a complex claim progresses through the system. There is no one case manager that "manages" the claim throughout its duration. One approach is to have a case manager manage all aspects of a claim, referring to the experts in each area, e.g. Medical Advisors, Vocational Rehabilitation Consultants, Disability Awards Officers etc. throughout the longevity of the claim. With the ultimate responsibility for a claim in the hands of one case manager this would provide better customer service, a more effective approach in managing claims, and a sense of ownership on the part of the case manager." (WP300, p.22)

3.2.24 When asked at a commission hearing who the Board will use for the physician component of case management, the Director Medical Services replied: “They will be the medical advisors we have now subject to training and adaptation to the new model. Our regular medical advisors will become the key medical component of the case management model." (WP472)

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
3.3.1 The 1996 Compensation Services Business Plan reports on the objective to improve customer service and consolidate Return to Work activities, and significantly reduce file transfers by the repetitive strain injury file transfer. The status was: successful decentralization to Kamloops, Victoria and Abbotsford SDLs. Comprehensive training package developed. Decentralization to Area Offices to be substantially completed in 1996. (WP300, p.7)

3.3.2 In an interview, the Director, Medical Services noted that Disability Awards is changing the process of PFI exams. Some of his staff doing PFI's but not as part of claims management. This is gradually evolving and being sorted out. (WP434, p.1)

3.3.3 "One of the aspects of the work teams that will be piloted in Coquitlam is the introduction of an Occupational Health Nurse to the work teams. The role of this position will be to assist in the development of case management plans for injured workers, be the first point of contact with the worker's general practitioner in clarifying the medical plan for the worker (including return to work), and assisting in the development of return to work programs with employers. The Medical Advisor's role will be to provide expert advice on complex claims, conduct At Board examinations, and provide other medical input and liaison with the medical community, as required." (WP300, p.37)

3.3.4 Practice Directives #12: Claims management and the continuum of care includes a program description with the variations that might be encountered, and adjudicative guidelines. It describes the major Nurse Advisor's role in initiating treatment, as well as when to consult a Medical Advisor on fitness to return to work, and maintaining rtw issues. (WP152, p. 1, Ch. 12)

3.4 the necessary delegations of authority and decision-making have been made

3.4.1 The 1996 Compensation Services Business Plan stated: "Effective February 1, 1995, this [ASTD] customer service initiative was launched in Victoria and Kamloops, Each office received the backlog of ASTD claims belonging to their areas from the queue in ODS which historically had been handled centrally along with the other occupational disease claims for the entire province. By the end of May, both offices had cleared their respective backlogs and now are processing incoming STD claims on a current basis." (WP300, p.43)

3.5 these responsibilities etc. are communicated and well-understood

3.5.1 The 1992 Permanent Disability Evaluation Schedule lists conditions an injured worker might experience with the percentage of total disability that can be assigned. Included are: amputations, immobility, shortening, denervation, impairment of vision, impairment of hearing, compression fractures, and loss of range of motions. (WP317)
3.5.2 In 1993, J. Dorsey then Chairman of the Board of governors gave an address to the WCB Medical Advisors Meeting where he commented that few of the doctors are accredited specialists yet their opinion may weigh more with adjudicators as they have a close working relationship. They do not perform medical procedures nor prescribe medication. Their role is advisory and their responsibility and accountability is decidedly behind others at the Board. (WP214, p.2)

3.5.3 The Permanent Functional Impairment Outline was revised in August 1995. It included discussion of: assessment of functional impairment, nervous system, vision, hearing, upper extremities, hand lower extremities, spine and pelvis, and devaluation, enhancement, and age adaptability. (WP316)

3.5.4 Under health care management, the Compensation Services Business Plan 1996 cites the objective to encourage appropriate and necessary care in a timely fashion and through the use of Clinical Practice Guidelines to improve the quality of health care and make it more cost effective. The CPGs for Low Back Bain were in the final stage of completion. It involved internal parties and the Council of CPGs, a joint BCMA/Government committee. (WP300, p.8)

3.5.5 The 1996 Orientation tutorials included guidelines for Board officers requesting medical opinions and guidelines for medical advisors rendering medical opinions. (WP309, Sec.1)

3.5.6 As noted above, the Director, Medical Services in an interview stated that during this transition period, with the introduction of Nurse Advisors, “there is probably a fair degree of scatter” regarding whether an adjudicator refers to a Medical Advisor or Nurse Advisor. (WP434, p.2-3)

3.5.7 The External Preferred Provider (EPP) Project has two reference manuals which describe the protocols and procedures for Disability Awards staff. (WP325, p.1)
Hypothesis 4: THE DIVISION PROVIDES AN APPROPRIATE WORK ATMOSPHERE

CCAF attribute: 10

Evaluation criterion:

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 for this hypothesis is mixed.

There is evidence to support increased involvement by physicians in WCB service improvement projects. Upgrading technical skills and an increased commitment to research has improved the professional development climate. We do not have any data to-date on the extent of peer reviewed research publications by WCB Medical Staff. There is very little data on the climate or working environment that physicians at the Board experience.

There is general evidence that staff in the Division have experienced a considerable amount of stress in the recent years' transitions. There is no evidence that the staff of Medical Services have been immune to this, and no documentation concerning the support staff's situation at all.

There has been evidence of concerns 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.

Research Findings and Evidence

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

4.1.1 The research team did not conduct any interviews with Medical Services staff other than the Director. Thus, there is no evidence from non-management staff.

4.1.2 As noted in Section 3 above, the Director, Medical Services in an interview noted that for some years, perhaps 10 to 20, the Department probably did not have the right people in right kinds of posts. There was no support policy or practice service guidelines; the Department did not capitalize on the opportunities open to it and did not contribute to the organization as well as it could have. This was partly due to nature of the people, and partly to the hiring process and salary scales. “This shifted in the early 1990's with a wave
of new younger people, more current, more activist, with more to contribute and more willing to contribute.” “Medical culture within the Board has gone through a darker phase, but it is better now and we are trying to build on this to establish greater cohesion within the group.” He has instituted more communications, which has led to “a better atmosphere, clearer understanding of what is happening, what expectations are... and improved morale.” (WP434, p.2-4)

4.1.3 When asked at a commission hearing how a Medical Advisor would be hired and oriented, the Director responded: "It has been a while since the Board took on a new medical advisor. You would start off with a fairly thorough orientation to the role of Board medical advisors. I believe that it would probably be 1 to 2 months of medical orientation basically understudying an experienced medical advisor in the field and working in one of the area offices.

Q: Is there a written curriculum on that or is it a mentoring program?
A: It is a mentoring program and there is an extensive orientation manual of which there is an expectation to be knowledgeable about it. Quite a lot of that is detail and background around Board policy, about management of the medical side of claims and also about the policy relating to the medical component of causation and so on.

Q: Is there an evaluation at the end of that 1 to 2 months?
A: There is a regular evaluation program done annually.

Q: That is done every year?
A: I believe that it is done annually.
Q: Is that done by you the director?
A: Me and there are three senior medical advisors who take responsibility for that.
Q: What about continuing education.
A: Continuing education is in two parts. There is the mandatory requirement of 50 study hours annually as recognized by the medical CME groups and there is an equal additional amount of time funded within the agreement for program related training related to the area of work within the organization." (WP472)

4.1.4 The Orientation Manual for WCB Physicians referred to by the Director, above, contains orientation tutorials, notes for practicum, vocational rehabilitation, disability awards, quality assurance and performance standards, and examples of forms in common usage. (WP309)

4.1.5 The Procedure Manual for Physicians includes discussion of emergency and safety procedure, human rights policy (harassment). (WP311, Sec. 1, 2)

4.1.6 The draft 1998 RCSD Business Plan notes that "Staff need to be coached and trained in order to prepare for business changes. Outlooks need to correlate to the new way of doing business as well as business processes and technology" There is an opportunity to redefine the role of Medical Advisors and broaden their skill sets during the transformation of the Board. (WP269, p.35, 36)
4.1.7 The 1996 Administrative Inventory reported that "Recent efforts in the Department have concentrated on upgrading the technical competence of the staff and encouraging their broader exposure to the community, both through worksite visits and scholarly research and publication." (See also Hypothesis 11) (WP18, p.37)

4.1.8 Medical Services staff are involved in project teams for Case Management, E-files, Clinical Practice Guidelines, and Continuum of Care. “These initiatives ensure medical staff have input and it provides them with an opportunity for "learning, skill development, and service improvements”. (WP1, p.30)

4.1.9 "The roll-out of ASTD claims to the Victoria, Kamloops, Abbotsford and Courtenay SDL's has gone well. All Area Office Medical Advisors have received ASTD training in preparation of the continued roll-out of these claims." (WP300, p.61)

4.1.10 In an interview, the Director, Medical Services reported that a clinical review team of himself, the two Co-directors of the Rehabilitation Centre, the Director, Psychology, and managers from Vocational Rehabilitation Services, Continuum of Care, and Head Unit and the Hand Unit have spent six days at six different SDL's. They conducted a clinical review of active files focusing on uptake/usage of clinical services, and the continuum of care. Each team member worked with an adjudicator. They discovered that there is a lot of variation between SDL's on effectiveness, and use of the new MA role. They also looked at the Nurse Advisor role, but it is too new a position to judge yet. They plan to do the same in area offices. He plans to use this information to fuel the performance evaluation and training processes. It will also help with further refinement of the role, model and activation of Medical Advisors. (WP434, p.3)

4.1.11 The Medical Advisory Committee Terms of Reference state that the Committee “was formed in May, 1994 in response to a recommendation made in the Fulton Report [Administrative Inventory] of May, 1993. The Fulton Report states 'Physicians should be afforded the opportunity of a medical or professional advisory committee, to bring their professional issues forward to senior management.' Doctors representing areas within the Board met with senior management and drew up Terms of Reference. These terms were approved by the Senior Executive Committee.” (WP313)

4.1.12 The Medical Advisory Committee minutes record that "In addressing the comments regarding the anxiety of the Board physician community. Ron Buchhorn reinforced the fact that this is a transitional time and during this phase there will be realignment of physicians, but other than attrition, there will be no loss of jobs. This change will not diminish the role of the physician, but enhance it. There will be a balance of roles between the Medical Advisor and Nurse Advisor.” (WP313)

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

The BCFL recommends that “Board policy be amended to provide for more weight to be given to the opinions of worker's physicians. The BCFL also recommends that the governing body of the Board establish (in consultation with the community) and publish standards of medical care and professionalism to be applied to Board medical staff. Finally, the BCFL requests that the Commission recommend that the BC Medical Association recognize Occupational Medicine as a specialty, as is the case in most other provinces.” (WP447, p.4-5) [The research team is advised that the College of Physicians and Surgeons is responsible for Occupational Medicine and does recognize the specialty.]
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

The evidence does not adequately support the hypothesis. There is no evidence to date for criteria 5.5 and 5.9. The remaining criteria have partial evidence.

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 and in Medical Services. There is no management information system for the Department, and no documentation that one is planned. The review has found that a limited range of performance information is supplied to Medical Services. As mentioned previously, activity-based data is available, 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 not only this hypothesis but many others. For example, it is difficult to plan adequately, assess achievements, or prepare for future contingencies in an information vacuum.

Research Findings and Evidence

5.1 the Division has identified, monitors and reports regularly and accurately the key items that are crucial for accountability (success/failure)
5.1.1 In an interview, the Director, Medical Services stated that there is “No Medical Services Management Information System”. They do have workload data, but no claims based MIS. (WP434, p.4)

5.1.2 An ongoing objective reported in the third quarter of 1996 is the "attending physician duration — outliers database" development and analysis. (WP14, p.18)

5.1.3 Key Indicators for Compensation Services have been developed and are reported in the Compensation Services Operating Report. For Medical Services the timeliness of opinions and examinations is reported year to date. (WP305, p.6)

5.1.4 The November 1997 Compensation Services’ Performance Report includes data on queues for medical services for the Lower Mainland and Area Offices. Data are also available on the number of medical opinions, exams and visits completed year to date. (WP60, p.15-16)

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.

5.2.1 The Division generally is challenged by the weakness of its management information.

5.2.2 The performance measures that are collected — the number of medical opinions, exams and site visits completed — are straightforward and there is no evidence to suggest that they are cumbersome or time consuming to collect.

5.3 The indicators used actually measure performance and organizational strength (i.e. they are meaningful).

5.3.1 A 1994-95 Board study on Prediction of Return to work Based on Clinical Impairment & Socio-Demographic Variables in Workers with Loss of Earnings Pensions showed that 28% of variance in return to work was accounted for by PFI, age, education, wage and language (all injury sites). That is, for all injury sites, 18.7% of variance is explained by socio-demographic factors, 3.7% by PFI, and shared .5%. However, the lack of documentation for these results means further investigation is required before they can be used with confidence. (WP115, p.14, 16)

5.3.2 The Association of the Workers’ Compensation Boards of Canada in its 1996 report Clinical Pilot Study of Biopsychosocial Measuring Instruments (part of the ‘Multivariate Prediction of Disability: Low Back’) noted: "For any prediction of disability to be valid, it is essential that the measurement tools be reliable (repeatable) and valid (true to the task). This would apply to medical or psychological assessment, or to any other data collected in a workers' compensation system. If assessment tools are not sound (reliable and valid), results that follow will be spurious (inaccurate and mistaken). Critical and costly decisions in workers' compensation boards rest on informed data. In the case of WCB BC, results from a recent LOE low back retrospective study demonstrate that optimal data in the system could account..."
for only 21.7% of the variance in long term disability. Accordingly, 78.3% of variance was unexplained — that is, the Board's current data is grossly inefficient to understand what drives disability in this population. Without knowledge there cannot be effective case management and rehabilitation, as well as fair and equitable adjudication." (WP111, p.5)

5.3.3 The Angus Reid WCB Claimant Satisfaction surveys collect data on satisfaction with Board doctors and specialists. The analysis notes that these ratings “should not be directly compared to the corporate results because the populations are not the same.”

"The questionnaire changed in Wave 7 and subsequent waves to identify those claimants whose last point of contact was a WCB doctor or specialist and those who have seen a WCB doctor or specialist in the last six months for their most recent claim. In addition, the list of service attributes was expanded in order to be similar to that on which other WCB staff members are evaluated."

5.3.4 In their submission to the commission, Cominco reported their frequency of lost time incidents has dropped over the last four years, as have the severity rates. “Severity ratings are needed and problematic for WCB."

5.3.5 Medical Services Department does collect data on the numbers of medical opinions, exams and site visits. The analysis of the Administrative Inventories, which was conducted for the commission, notes that “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." (WP102d, p. 17, Chap. 2)

5.4 performance information is provided on a timely basis so that results can be used in other management processes (planning, budgeting)

5.4.1 There is insufficient evidence to comment on this criteria.

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

5.5.1 In a 1993 Address to Medical Advisers Meeting, J. Dorsey, then Chairman of the Board of Governors commented that measurable standards for customer service will be part of performance standards used to evaluate doctors. (WP214, p.7) The research team did not see any evidence to suggest that such standards have been introduced.

5.5.2 The 1996 Operational Manual for WCB Physicians notes that "In May 1991, the Medical Advisors initiated a quality assessment program based upon the following principles:
1. Peer review.
2. Periodic, random, concurrent review.
3. Review by multiple peers simultaneously."
4. Rotation of review function.
5. Standardized review format.
6. Quality enhancement resulting from:
   a) Reviewers' exposure to peers' work.
   b) Feedback from multiple reviewers resulting in greater consistency of Medical Advisor performance.

The program currently consists of [some of] the following elements:
1. Each month ten AB exam reports and ten files with medical opinion memos from each of one metro and one area office Medical Advisor are reviewed by peer reviewers.
3. One Senior Medical Advisor and one Medical Advisor independently review these materials according to the criteria listed on the attached A checklists.
7. Every six months a different Senior Medical Advisor and Medical Advisor serve as reviewers. The Medical Advisors reviewer alternates between metro and area office Medical Advisors.
8. In this manner, approximately 24 Medical Advisors are reviewed annually, thus allowing each physician's work to be reviewed approximately annually." (WP309, Sec. 5)

5.5.3 The Board’s 1997 briefing paper *Health Care Issues under the Workers’ Compensation Act* states:

"As part of its study of factors affecting duration of disability, the WCB has conducted a review of the number of days of wage loss paid for each of the 17,999 short term disability claims for sprains/strains and low back injuries 'finalled' between January 1, 1995 and May 31, 1996. In identifying the number of days paid for each claim and the average number of days paid to the patients of each attending physician, the WCB has found evidence of possible substantial variation in duration across physicians. The WCB is making the results of its review known to the physician community. It will then undertake discussions with individuals at both ends of the spectrum to determine whether there are significant variations in treatment provided. Educational opportunities will be made available to outliers. These opportunities will be tied to the development of the 'Clinical Practice Guidelines' outlined above. The WCB will also be focussing on the number of times a physician treats an injured worker. It has long been assumed that attending physicians act as 'gatekeepers' to other treatment providers. This may not be occurring in actual practice and the individual physician may not have any influence over the duration of the individual claim." (WP155, p.15)

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

5.6.1 As noted above, the Department does not collect outcome data.

5.7 reports present data/information and analysis that is accurate, reliable, consistent, complete, meaningful, timely, replicable, impartial and that states assumptions used
5.7.1 As noted above, the Department does not collect outcome data.

5.7.2 Data related to medical opinions, exams and site visits is reported in planning documents.

5.8 reporting is subject to verification/audit

5.8.1 Issues regarding MIS have been identified by internal audit. (WP170, p.3)

5.9 performance information is the basis on which decisions are made

5.9.1 There is insufficient evidence to comment on this criteria.
Hypothesis 6: THE DIVISION IS ACHIEVING ITS OBJECTIVES

CCAF attributes: 1 (in part), 3, 4, 5

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

The hypothesis is partially supported by the evidence.

There are not very many measurable goals, objectives or Critical Success Factors for Medical Services in the 1997 and 1998 Business Plans. There are no specific, measurable and timebound objectives for the Department in the documents reviewed to date. Consequently, it is not easy to validate the direction of the Department and whether it is achieving its aims. There is some evidence that the Department has achieved activity goals in the past (e.g., meeting timeliness goals in 1995).

The Department is trying to be proactive, for example, shifting the role of the Medical Advisor to an earlier intervention process. The Department has been involved in initiatives that are relevant to key issues in workers' compensation and rehabilitation. An example of this is the adoption of Clinical Practice Guidelines for Low Back Pain.

Although concerns have been raised regarding constituencies' satisfaction with Medical Services, this requires careful investigation. The methodology for collecting this type of information could be critical. For example, 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.

There was no evidence that Medical Services has assessed secondary or unintentional impacts.

Research Findings and Evidence

6.1 the Division is achieving what is set out to do

6.1.1 In correspondence with the commission, the Board provided the following information for the years 1994-1997.
The three major activities measured for the Medical Advisors in the Service Delivery Locations and in Occupational Health are examination, opinions, and work site visits. Opinions do not involve direct client contact; examinations and work site visits do.

It is estimated that 90 percent of time is devoted to these activities. It is estimated that 1 examination (including PFI examinations in the SDL’s and AO’s) = 1 work site visit = 8 opinions rendered.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Exams*</th>
<th>% of Time</th>
<th>Number of Opinions</th>
<th>% of Time</th>
<th>Number of Work Site Visits</th>
<th>% of Time</th>
<th>% of Time in Direct Contact with Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994**</td>
<td>8,742</td>
<td>47</td>
<td>61,140</td>
<td>40</td>
<td>524</td>
<td>3</td>
<td>50</td>
</tr>
<tr>
<td>1995</td>
<td>9,427</td>
<td>45</td>
<td>70,707</td>
<td>42</td>
<td>519</td>
<td>3</td>
<td>48</td>
</tr>
<tr>
<td>1996</td>
<td>9,331</td>
<td>47</td>
<td>62,165</td>
<td>40</td>
<td>536</td>
<td>3</td>
<td>50</td>
</tr>
<tr>
<td>1997</td>
<td>5,161</td>
<td>43</td>
<td>39,305</td>
<td>42</td>
<td>630</td>
<td>5</td>
<td>48</td>
</tr>
</tbody>
</table>

• excludes PFI examinations performed by Richmond DAMA’s
** excludes Occupational Health

The Board also estimates that its specialists and DAMA’s in Richmond spend approximately 50% of their time in contact with clients.

6.1.2 The documents present information on activity levels: the numbers of medical opinions rendered, the number of examinations conducted and the number of site visits completed. In some instances, these are compared against goals set. The following tables are examples of this reporting:

• 524 worksite visits were performed in 1994. This was a new activity and reportedly well-received by workers and employers. It was accomplished as hoped at the expense of file reviews rather than medical examinations.

• The 1996 Compensation Services Business Plan (WP300, p.62) notes that 1995 goals for timeliness of medical examinations and for medical opinions in the SDL’s (excluding Occupational Health) were exceeded:

<table>
<thead>
<tr>
<th></th>
<th>1995 Goal (days)</th>
<th>1995 Actual (days)</th>
<th>Best Month (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examinations</td>
<td>12.7</td>
<td>11.9</td>
<td>9.9</td>
</tr>
<tr>
<td>Opinions rendered</td>
<td>3</td>
<td>2.9</td>
<td>1.5</td>
</tr>
</tbody>
</table>
• The 1996 Compensation Services Business Plan (WP300, p.10, 66) provides historical data and budgets:

<table>
<thead>
<tr>
<th></th>
<th>1993 Actual</th>
<th>1994 Actual</th>
<th>1995 Budget</th>
<th>1995 Actual</th>
<th>95 Act over 95 Budget Inc/(Decr)</th>
<th>95 Act over 94 Actual Inc/(Decr)</th>
<th>1996 Budget</th>
<th>96 Budget over 95 Actual Inc/(Decr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Exams</td>
<td>12,346</td>
<td>12,590</td>
<td>13,000</td>
<td>13,178</td>
<td>(0.9%)</td>
<td>4.7%</td>
<td>13,500</td>
<td>2.4%</td>
</tr>
<tr>
<td>Medical Opinions</td>
<td>64,378</td>
<td>61,140</td>
<td>64,200</td>
<td>65,701</td>
<td>2.3%</td>
<td>7.5%</td>
<td>65,000</td>
<td>(1.1%)</td>
</tr>
<tr>
<td>Physicians’ work site visits</td>
<td>n/a</td>
<td>517</td>
<td>550</td>
<td>441</td>
<td>(19.8%)</td>
<td>(14.7%)</td>
<td>400</td>
<td>(9.3%)</td>
</tr>
</tbody>
</table>

• The 1996 Plan also shows volumes and timeliness over time (WP300, p.63):

<table>
<thead>
<tr>
<th>MEDICAL SERVICES DEPARTMENT (EXCL. OCC. HEALTH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volumes</td>
</tr>
<tr>
<td>Medical Opinions</td>
</tr>
<tr>
<td>Examinations</td>
</tr>
<tr>
<td>Worksite Visits</td>
</tr>
<tr>
<td>Timeliness (Days/SDL's)</td>
</tr>
<tr>
<td>Medical Opinions</td>
</tr>
<tr>
<td>Examinations</td>
</tr>
<tr>
<td>PFI Examinations</td>
</tr>
</tbody>
</table>
The RCSD Operating Report for First Quarter, 1997 compares first quarter 1997 activities with those for the same period in the previous year. A note to the table explains that “The count of examinations includes those for Permanent Functional Impairments (PFI's), consultations and "at-board" (AB) examinations. The decrease in the first quarter of 1997 is primarily a result of fewer AB exams due to the changing role of the Medical Adviser in the SDL's. There is now an increased emphasis on activities other than exams to encourage an early and durable return to work.” (WP306, p.6)

<table>
<thead>
<tr>
<th>Activities</th>
<th>1994</th>
<th>1995 (Mar-Dec)</th>
<th>1996 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Volumes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Opinions</td>
<td>N/A</td>
<td>5,006</td>
<td>5,600</td>
</tr>
<tr>
<td>Examinations</td>
<td>N/A</td>
<td>310</td>
<td>500</td>
</tr>
<tr>
<td>Worksite Visits</td>
<td>N/A</td>
<td>78</td>
<td>110</td>
</tr>
<tr>
<td><strong>Timeliness (Days)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Opinions</td>
<td>N/A</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td>Examinations</td>
<td>N/A</td>
<td>N/A</td>
<td>11</td>
</tr>
</tbody>
</table>

The RCSD Operating Report for YTD June, 1997 compares activity levels for the second quarter of 1997 with those for the same period in the previous year. A note to the table explains: "Examinations and opinions are down significantly from 1996. This has been achieved primarily in the lower mainland SDL's and is the result of a successful ongoing effort to revamp the role of the Medical Advisor moving towards case management and the continuum of care. In Prince George, where case management is being piloted, opinions and examinations are down 19% and 50% from 1996, respectively." (WP307, p.8, 11)
<table>
<thead>
<tr>
<th></th>
<th>2Q97</th>
<th>2Q96</th>
<th>Incr (Deer)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examinations</td>
<td>4,943</td>
<td>6,933</td>
<td>(1,986)</td>
<td>(28.6)</td>
</tr>
<tr>
<td>Medical Opinions</td>
<td>24,121</td>
<td>33,036</td>
<td>(8,870)</td>
<td>(26.8)</td>
</tr>
<tr>
<td>Worksite Visits</td>
<td>294</td>
<td>269</td>
<td>25</td>
<td>9.3</td>
</tr>
</tbody>
</table>

6.1.3 There have been changes over time in recording activities. The Rehabilitation & Compensation Division Operating Report for 1996 notes that “in 1996 the department discontinued the counting of ‘walk-ins’ as opinions rendered.” (WP305, p.13)

6.1.4 The documents reviewed also presented some information on timeliness; for example:


<table>
<thead>
<tr>
<th></th>
<th>YTD Dec 96</th>
<th>YTD Dec 95</th>
<th>Improvement/ (Deterioration)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness of Opinions (days)</td>
<td>3</td>
<td>2.9</td>
<td>-0.1</td>
</tr>
<tr>
<td>Timeliness of Exams in SDL’s (days)</td>
<td>10.6</td>
<td>11.9</td>
<td>1.3</td>
</tr>
<tr>
<td>Timeliness of PFI Exams (days)</td>
<td>35.1</td>
<td>42.4</td>
<td>7.3</td>
</tr>
</tbody>
</table>

- The RCSD Operating Report for First Quarter, 1997 notes that there was a 25% decrease in the timeliness of opinions between the first quarter in 1997 and the first quarter of 1996, while the timeliness of medical exams increased by 33.3%. The Department reported that improvement in the punctuality of documenting opinions over the rest of 1997 was expected. The more timely examinations were made possible by the "decreased requests and reliance on the 'AB' exams. (WP306, p.11)

- The RCSD Operating Report for First Quarter, 1997 notes that timeliness of opinions stayed the same between 2Q96 and 2Q97 at 2.8 days. The timeliness of medical exams at SDLs improved from 11.4 days to 6.0 days over the same period. This is an improvement of 47.4% attributed to the decrease in requests for and reliance on at Board exams. (WP307, p.13)

6.1.5 There are a few references that link activity levels and changes with intended outcomes. Examples include:

- The Rehabilitation & Compensation Division Operating Report for 1996 notes that exams and opinions decreased in 1996 due to a reduction in the number of Medical Advisers, a decreased reliance upon MA’s for adjudicative decision making, and an
increased emphasis on the part of the MA's to assist adjudication staff through liaison with the attending physicians.

- A report on the Repetitive Strain Injuries (RSI) pilot project was given to the Executive Committee in September 1994. "Preliminary findings indicate positive short term intervention effect. Long term effect and outcomes to be determined. Consideration should be given to implementation of early intervention RSI strategy in conjunction with ODS activities and initiatives on an ongoing basis." (WP112z2, p.3)

- "The decrease in the number of opinions is the result of the lessened reliance on the MA's in addition to utilization of informal consultations with the MA (which are not tabulated) rather than documented opinions. (WP306, p.6)

- Work site visits have been emphasized in 1997 as an effective activity to achieve successful returns-to-work. Board physicians got out on the road and made nearly 15% more than the same period in 1996." (First Quarter 1997 Operating Report., WP306, p.6)

6.2 the programs/services the Division delivers are relevant

6.2.1 The 1994 WCB Annual Report indicated that the "coordination of rehabilitative services closer to workers' homes resulted in a 10 percent reduction in volume [at the Rehabilitation Centre] over last year, while treatment days at the Centre remained constant as a result of its focus on more complex cases." (WP350, p.21)

6.2.2 The 1998 Business Plan states that "Transformation of the department has been driven by our clients, both internal and external, as well as the general public's increasing expectation of better and more timely services." (WP269, p.35)

6.2.3 The CMA’s 1997 policy summary ‘The physician’s role in helping patients return to work after an illness or injury’ 1997 states: "Successful return to work involves primarily the employee and his or her employer and requires the assistance of the attending physician. When appropriate, patient care and outcomes may be improved through a coordinated multidisciplinary approach involving other health care professionals, including other physicians, rehabilitation specialists, nurses, physiotherapists, occupational therapists, psychologists, case managers, vocational specialists and personnel of employee assistance programs. When available, occupational health and safety services, which may involve physicians and other expert personnel, can be an invaluable resource for the attending physician and patient." (WP43, p.2) This supports the interdisciplinary approach used at the WCB.

6.2.4 WCB Medical Advisory Committee Minutes July 19, 1995 note that the first draft of the Clinical Practice Guidelines “was introduced with a suggestion that the draft be taken to a
broader base consultative committee of doctors. That will allow the medical approach at the Board to meet the medical approach from the outside." (WP313)

6.2.5 Despite attempts to make Medical Services programs relevant, the Director, Medical Services, stated in an interview that "Currently, medical services relate to the process, not to direct care.” Case management is seen as a significant opportunity for Medical Advisors on the team to influence the care process itself e.g. timing, care treatment, use of diagnoses. He can see the day when the Board will be able to compare cost of care, types of intervention between area offices and SDL’s and draw conclusions regarding the effectiveness and influence of the Medical Advisor. “The Board is moving towards this but is not there yet. It will make a profound difference. For example, it will enable the Board to say ‘this type of operation on low backs is not effective at x weeks — and here is what it is costing’. It will allow this type of information to be taken to the case management decision-making table." (WP434, p.5)

6.3 the constituencies to which the programs/services are directed judge them to be satisfactory

6.3.1 Clients have charged that Board Doctors are insensitive to cultural and language differences and, also, that Board doctors are not advocating for clients. (WP252, p.20-21)

6.3.2 Clients complained about a lack of information on their program and progress. Clients complained about physician attitude and practice. Clients treat Facility physicians with suspicion and rely on their family doctor to ensure that their needs are met. (WP252, p.43)

6.3.3 "A small client satisfaction survey was conducted in 1994 (123 respondents) to gather feedback from Medical Services Department clients. The survey indicates that clients/respondents were comfortable with the structure and conduct of their examination. About 93 percent agreed or strongly agreed that the doctor explained the purpose of the examination, and 97 percent said that the doctor treated them with respect and courtesy. However, only 76 percent agreed with the recommendations of the doctor, as might be expected when dealing with issues of benefit entitlement." (WP18, p.37-38)

6.3.4 Compensation Services Division Performance Report 1st Quarter 1996 noted that overall Client Satisfaction with the doctors services was rated at 6.8 on a ten point satisfaction scale. Ratings of 6 or 7 are interpreted as neutral. Out of 275 claimants, 116 gave a rating of 5 or less for a particular service item. Reasons given for these ratings are: the doctor is perceived to be giving a misdiagnosis, isn't knowledgeable about cases, doesn't care, is a poor listener, does not answer questions and rushes the claimant back to work. (WP13, p.1)

6.3.5 The Orientation Manual for WCB Physicians notes that "Client satisfaction surveys have been conducted. Follow-up surveys are planned." (WP309, Sec.5)

6.3.6 Client satisfaction was discussed by the WCB Medical Advisory Committee in 1997. "When discussed at SEC, consideration was given to concerns, but it appears nothing has been done to improve the environment. There still appears to be a problem. Action: Ron will talk to
physicians in Abbotsford, but pointed out that complaints do not appear to be coming from patients, but rather physicians and perhaps there is a cultural adjustment necessary. Ron will continue to monitor the situation, and outlined the acceptance of an open concept that is now used at ICBC and BC Rail. But clearly expressed, that if we breech people’s ability to do their job in a professional way, then we must look at it again.” (WP313)

6.3.7 In an interview, the Director, Medical Services confirmed that the only satisfaction measure related to his Department is “the Angus Reid analysis of C claimants who have direct contact with Medical Advisors. Angus Reid do not survey attending physicians or private practitioners. In the new Medical Advisor role, private practitioners are key.” He wants the Angus Reid survey to be extended to include these people. “This will likely happen when the Angus Reid contract is revisited.” (WP434, p.6)

6.3.8 The Angus Reid WCB Claimant Satisfaction W13 (wave 13) noted: "As mentioned in previous reports, WCB doctors/specialists deal primarily with C claimants who, as we know from the corporate research, are the most dissatisfied. The ratings for the WCB doctors/specialists should not be directly compared to the corporate results because the populations are not the same.”

The questionnaire changed in Wave 7 and subsequent waves to identify those claimants whose last point of contact was a WCB doctor or specialist and those who have seen a WCB doctor or specialist in the last six months for their most recent claim. In addition, the list of service attributes was expanded in order to be similar to that on which other WCB staff members are evaluated.

Wave 13 reported the following:

“Evaluation of Service Attributes: Following a universal increase that took place in Waves 10-12, every service attribute has now decreased at least slightly in Waves 11-13. The decreases have added a few more services to the list of those with a ranking under 7.0: familiarity with your case, fairness, care and concern, ability to explain condition, ability to understand your needs, appearance and ability to provide medical information. No service items have a rating over 8.0.

“Overall Service: This rating refers to claimants’ evaluation of the overall service provided by the WCB doctor or specialist. It does not refer to overall satisfaction with the WCB. The rating for overall service is 6.8 down from 7.2 last wave.

“Reasons for Dissatisfaction: One-hundred and sixteen claimants gave a rating of 5 or less for one or more service items. Reasons for low ratings centre on the thought that the doctor is giving a misdiagnosis, isn't knowledgeable about cases, doesn't care, is a poor listener, does not answer questions and rushes the claimant back to work."

"The results in this report include Waves 11, 12 and 13 for a total of 275 claimants (margin of error + 5.9% at the 95% confidence level)."
6.3.9 Physicians’ dissatisfaction was expressed by the BCMA in its submission to the commission: "The BCMA recognizes that the proposed fee-for-service agreement between the WCB and BCMA should address some of these concerns. The proposed agreement includes important improvements including:

- a payment system which guarantees payment to physicians within 45 days
- dispute resolution between MSP and WCB which does not interfere with payment of the physician
- implementation of a telephone dictation system for forms and reports
- payment to physicians for telephone inquiries made by WCB staff." (I-EMA-064, p.18)

6.3.10 The BCMA submission also stated: "WCB patients most often raise the following four concerns: poor communication from the WCB, inconsistency of case managers, non-physician care decisions, and long waiting periods." (I-EMA-064, p.29)

6.3.11 The BCFL submission noted: "A common complaint of workers is that Board medical advisors are insensitive and distrusting. They ask why they have to see a Board doctor with no particular specialty qualification when their specialist says they cannot return to work. Workers also ask why the opinions of Board medical advisors are so often at odds with their own doctors, preferred to treating physician's, and often rejected on appeal. Our experience is that doctors themselves also ask these question. Recommendation 4: The BCFL recommends that Board policy be amended to provide for more weight to be given to the opinions of worker's physicians. The BCFL also recommends that the governing body of the Board establish (in consultation with the community) and publish standards of medical care and professionalism to be applied to Board medical staff. Finally, the BCFL requests that the Commission recommend that the BC Medical Association recognize Occupational Medicine as a specialty, as is the case in most other provinces." (WP447, p.4-5)

6.4 The Division is able to identify secondary impacts and eliminate those that are negative, and build upon those that are positive

6.4.1 Worksite visits were a new activity introduced in 1994. These are “reportedly well-received by workers and employers.” However, as noted in the 1996 Compensation Services Business Plan, "Productivity of Medical Advisors has remained relatively constant in 1995 from previous years except in the number of worksite visits conducted. These have decreased in order to divert more resources to opinions and exams.” This may actually indicate a change in productivity if the extra time is required to maintain the same workload in opinions and exams. (WP300, p.15)
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

Hypothesis 7 cannot be supported by the evidence available. Neither criterion is adequately supported by the evidence reviewed to date.

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.

Research Findings and Evidence

7.1 the Division is able to identify costs, inputs and outputs and determine the relationship between them

7.1.1 The Association of Workers’ Compensation Boards of Canada in its 1997 report *Compensating for Chronic Pain*, noted that the issue of chronic pain “was addressed by a task force in British Columbia, which estimated that the Workers’ Compensation Board of British Columbia, was dealing with at least 1,000 chronic pain cases at the six month interval, at a cost of at least $140,000 each.” (WP123, p.1)

7.1.2 The Director, Medical Services, in an interview confirmed that the Board cannot determine the cost effectiveness of its Medical Advisors. He can see the day when Board will be able to compare cost of care, types of intervention between area offices and SDL’s, and draw a conclusion regarding the influence and effectiveness of Medical Advisors. They are moving towards this but “we are not there yet. It will make a profound difference. For example, it will enable Board to say ‘this type of operation on low backs not effective at x weeks — and here is what it is costing’.” (WP434, p.5)

7.1.3 In the same interview, the Director, Medical Services commented on the 'Provider compare' software, which is part of the Risk Data project. Once in place, “it will provide the WCB with a unique opportunity to do cost of care analysis by e.g. type of provider, type of intervention.” (WP434, p.4)
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)

7.2.1 In an interview, the Director, Medical Services confirmed that the Department is not measuring outcomes, and so cannot determine its cost effectiveness. At present, it can only look at management costs such as the ratio of Medical Advisors to claims, and even this is not done on financial basis. (WP434, p.4)

7.2.2 In an interview, the Vice President, RCSD noted that he is convinced the Board could outsource most of its services for lower cost than they can deliver internally. (WP498, p.5) While some activity-based costing is proposed to ensure the data for cost effectiveness analyses is available, at this time it is not clear on what information the Vice President was basing his opinion.

7.2.3 Strategy #2 in the 1995 Business Plan is to: Develop a managed care strategy that would coordinate health care and rehabilitation services under one administration. Clinical practice guidelines would be developed, resulting in improved quality and cost effectiveness. (WP4, p.27)

7.2.4 The Orientation Manual for WCB Physicians comments: "Cost-effectiveness- Methodology for analyzing the cost and effect of each Medical Advisor activity needs to be developed." (WP309, Sec.5)

7.2.5 There have been sporadic attempts to grapple with the issue of cost effectiveness. These include:

- In a study by the Senior Medical Advisor, the Victoria Meniscectomy Review, the "results tend to confirm prior impressions that many individuals within the Medical Services Division held - namely, that surgical waiting times are longer in the major centres when compared to the smaller ones. However, it is very striking that from a monetary standpoint these waiting times are significant. The fact that over $425,000 was spent in 1992 just waiting for a definitive (usually) therapeutic operative procedure is quite staggering. The fact that this was in one region only (Victoria area) adds to the concern. Certainly, in this limited study one cannot even attempt to quantify all the non-monetary, human costs associated with such delays. There is little doubt that injured workers are not being treated in as timely a fashion as they should expect." (p.2)

- From "Health Care Issues Under the Workers Compensation Act": "As part of its study of factors affecting duration of disability, the WCB has conducted a review of the number of days of wage loss paid for each of the 17,999 short term disability claims for sprains/strains and low back injuries 'finalled' between January 1, 1995 and May 31, 1996. In identifying the number of days paid for each claim and the average
number of days paid to the patients of each attending physician, the WCB has found evidence of possible substantial variation in duration across physicians. The WCB is making the results of its review known to the physician community. It will then undertake discussions with individuals at both ends of the spectrum to determine whether there are significant variations in treatment provided. Educational opportunities will be made available to outliers. These opportunities will be tied to the development of the 'Clinical Practice Guidelines' outlined above. The WCB will also be focussing on the number of times a physician treats an injured worker. It has long been assumed that attending physicians act as 'gatekeepers' to other treatment providers. This may not be occurring in actual practice and the individual physician may not have any influence over the duration of the individual claim." (WP155, p.15)

• "Committed to continually improving the quality and cost-effectiveness of the rehabilitation services it delivers, the WCB engaged in innovative research in 1994. The Centre conducted a pilot project in the treatment of back pain, a persistent, widespread source of WCB claims, and another in the area of repetitive strain injuries, a growing claims source." (WP350, p.1)
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 partially supported by the evidence available to the researchers.

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, the Department is again hampered, as is the rest of the organization, by the limitations of internal information systems and the scarcity of information development (whether IS or research) resources. It is difficult to maintain or improve results if you don't know what they are or what affects them.

Research Findings and Evidence

8.1 the Division has the ability to maintain or improve results

8.1.1 In a 1993 Address to Medical Advisers Meeting, J. Dorsey, then Chairman of the Board of Governors, stated: "Some doctors have not kept current with the times and do not exhibit analytical ability that will withstand rigorous scrutiny. There are not many Board physicians who are leaders in research on rehabilitation or prevention." (WP214, p.5) This comment was made the same year that the 1993 Administrative Inventory recorded the physicians’ complaint that research initiatives are not supported by the Board.

8.1.2 "The WCB/BCMA Liaison Committee continues to address issues including clinical practice guidelines, WCB form revision and frequency of submission, as well as supervised care." (WP300, p.61)

8.1.3 In a presentation to the commission, the Director, Medical Services stated: "The provider-compare software and analysis process that was mentioned opened up quite an exciting
opportunity for the Board to study different types of care with different types of injuries and even with different kinds of practitioners as to the eventual outcome, the overall cost and the overall impact in terms of time loss from work as well as disability or the lack of it or recovery without disability over the whole case. It's actually a data set that the rest of the health care system does not have access to. The rest of health care is fragmented. No one else has the indemnity information around illness that this organization has. To pull that together will help us to discover some really quite useful things. For instance, the efficacy of certain kinds of treatment, their impact on return to work, the overall costs — both in terms of health care and in terms of the overall cost to the worker or even potentially to society. Some of that is a bit of a ways away because we need to get the data honed and refined on the front end, the nature of injury and the coding process has to be tightened up considerably and then the process of pulling together this sort of diverse data into an analysis package should give us some useful things. MSP has a collection of billing data but doesn't discuss diagnosis or treatment. Hospitals have tons of information on what occurs within their walls but nothing outside and Pharmacare has a separate link around prescriptions without any links to the other two." (WP472)

8.1.4 The Director also noted: "Our network of medical advisors is well positioned and informed to promote the use of case management and a planned approach to care aimed at improving clinical outcomes. We also have an opportunity to improve much broader outcomes for injured workers and for all WCB stakeholders such as more effective disability management and lower overall compensation costs." (WP472)

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

8.2.1 The then Chairman of the Board of Governors, J. Dorsey, in an Address to the Medical Advisers Meeting commented that "Board doctors may need to consider their role in assuring the future health of the injured worker. Other issues, such as literacy, training, addiction and personality problems require the attention and interest of Board doctors. The appropriate role for doctors in these issues is a matter for discussion." (WP214, p.6)

8.2.2 "The Medical Services Department is participating in the development of the UBC Undergraduate Medical School curriculum. This will increase these students' exposure to occupational health issues, commencing September 1997." (WP300, p.61)

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

8.3.1 The 1993 Administrative Inventory noted that community-based physicians have expressed frustration with WCB doctors. They perceive that their opinions are dismissed because they are not board doctors. Also that referrals are not always followed up and that the Board is not necessarily a patient advocate. (WP252, p.20)
8.3.2 At a commission hearing, the Director, Medical Services was asked: "It has been suggested that undergraduate medical education should be utilized to try to improve the knowledge of general practitioners in that regard. Is the Board liaising with the university in any way in terms of curricula for undergraduate medical students?" He replied:

“Yes that part is under discussion and historically there have been some members of the Board’s medical staff involved in various parts of the teaching program. Another bit of it is developing a liaison with the department of family practice at UBC to give them some of that information and perhaps even bring some of their trainees out here to do an elective or on a rotation to get a closer look at some of the issues around workplace injury. The only caveat that I have with that when I hear it is that it is a great idea and in 30 years we will have covered the whole profession. So it is desirable but only one end of the educational issue.” (WP472)

8.3.3 The Technology Assessment Committee Terms of Reference, dated January 1998, state:

- "Purpose: The TAC is established for the purpose of applying the established techniques of critical appraisal and evidence based medicine to the evaluation of health technologies, clinical treatment, assessments or diagnostic procedures, and such other questions arising from the provision of services to injured workers. The conclusions reached by the committee will be of a scientific nature and may be used by the WCB in reaching policy and practice decisions with regard to medical and rehabilitative issues.

- "Membership: The TAC will be chaired by the Director of Medical Services or a delegate. Core members of this multidisciplinary committee will be interested individuals drawn from the Rehabilitation Division. The BC Office of Health Technology Assessment will sit on the committee as an expert resource, as will additional outside experts as determined to be appropriate by the Core Committee.” (WP314, p.1)

8.3.4 At a commission hearing, the Director, Medical Services was asked whether the department that he heads is responsible for any research into the causes of workplace injuries? He replied:

“Not directly within my department. Now over time there has been a fair amount of research into some of the statistics and the information within the Board but in my short time here I haven't been involved with that. I would expect that there would have been some over the years in occupational medicine, for instance, and occupational diseases and other areas within some of the specific programs in rehabilitation.

“I would like to mention the other area, which is the rehabilitation centre where we have had medical involvement in research initiatives. We currently have a multivariate predictor study
that has medical involvement, Dr. David Hunt is involved in that. There have been other such studies out of the rehabilitation centre ... [Compensation Services physicians] are really medical advisors who would not participate as much as the Rehabilitation Centre physicians or the occupational disease physicians." (WP472)

8.3.5 A 1993 report by one of the Board’s Senior Medical Advisor noted: "It has been proposed that the Medical Services Division review what role MRI has in the investigation of injured workers with spinal "problems". As many of us are well aware, the use of MRI in the investigation of many known or suspected disease processes continues to expand. As with most imaging modalities, the indications for its use become more refined over time. While the United States would appear to have had more experience with MR imaging, there is little doubt that we in Canada, and more specifically here in BC, are not far behind. Certainly, as access to the technology grows and it becomes more readily available, then so will our firsthand experience." (WP322, p.4)

The conclusions and recommendations to the Board on the use of MRI for spinal "problems" were:

1. Magnetic resonance imaging is an excellent diagnostic tool which, when combined with a careful, comprehensive clinical assessment, has much to offer the Board in select cases of worker's spinal "problems".
2. MRI is not indicated for use in the investigation of the majority of workers with back or neck pain.
3. The use of MRI of the spine by both the Board and treating physicians has been increasing steadily and will likely continue to do so in the foreseeable future.
4. The present degree of accessibility that the Board has in place for MRI examinations is both reasonable and acceptable. There is nothing to suggest that a restrictive attitude toward MRI services would be of benefit to anyone in the long term.
5. There is little objective data to suggest that its use will result in any significant change in compensation costs. Anecdotally, the earlier use of MRI may have this effect but only time will prove this to be correct or not.
6. Injured workers subjected to MRI examinations have the benefit of the most advanced technology available that many non-workers in similar circumstances do not have ready access to.
7. CT is a more accessible technology than MRI on a provincial level. It is likely that CT scanning, CT myelography and myelography will continue to play a role in the investigation of workers with injured spines." (WP322, p.1-2)

8.3.6 Notes on a presentation by Dr. Blair to the commission: "The WCB can study different modalities now — the WCB is uniquely suited to collecting data and doing research on these modalities — but it will take a while for results." (WP484, p.4)
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 not fully supported by the evidence reviewed to date. There is no evidence for criteria 9.4 and 9.7. The remaining criteria have limited evidence.

Much of the information required to evaluate whether the criteria for this hypothesis are met comes from outside the Medical Services Department itself. Corporate and Division level policies, procedures, and processes seem to dominate the financial management of the Department. Consequently, much of the analysis is reported in Part 1 of this report. A thorough investigation of this hypothesis would require access to a completely different set of evidence than the researchers had access to. However, none of the evidence reviewed suggests that the Department is not setting and achieving its financial objectives in a responsible manner.

Research Findings and Evidence

9.1 the Division has set financial objectives

9.1.1 The Division considers the budgeting process to contain financial objectives. The Medical Services Department completes the budget in accordance with the process set for the WCB as a whole.

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)
9.2.1 In an interview with the Divisional Controller and the RCSD Manager, Finance and Administration, it was noted that Prevention Division projects how its activities may impact targeted injury rates and fatalities. RCSD use these projections to estimate claims costs, for budgeting purposes. They also look at trends. (WP473, p.2)

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*

9.3.1 Evidence to address this criterion was not made available to the research team.

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

There is insufficient data to comment on this criteria to-date

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

9.5.1 Quarterly operating reports do present year to date figures and variances. An example is shown below for the Second quarter 1997. (WP307, p.17-18)

<table>
<thead>
<tr>
<th>Medical Services</th>
<th>Q2 97 YTD Actual</th>
<th>Q2 97 Budget</th>
<th>Variance Fav/(Unfav)</th>
<th>Variance % Fav/(Unfav)</th>
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<tr>
<td>Permanent</td>
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<td>Temporary</td>
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<td>(FTE/M's/6)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Medical Services</td>
<td>Q2 97 YTD Actual</td>
<td>Q2 97 Budget</td>
<td>Variance Fav/(Unfav)</td>
<td>Variance % Fav/(Unfav)</td>
</tr>
<tr>
<td>Salaries</td>
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<td>3,995</td>
<td>299</td>
<td>7.5</td>
</tr>
</tbody>
</table>

9.5.2 Sometimes variances are explained. For example, the June 1996 Operating Report notes: "The unfavourable variances in SDS consulting has been offset primarily by favourable variances in Medical Sessionals ($48,000) and payment/timing delays related to the Performance Management Project ($100,000)." (WP304, p.13)
9.5.3 In other instances, variables, even significant ones, are not explained. A case in point is the Summary of Administrative Operating Expenses for 1995-1998 (presented under criterion 2.6 above) which shows significant changes. Net expenses in the 1998 budget are down by over 50%. (WP301, p.6) However, explanatory notes for the decreases in the 1998 Budget are not documented in the table.

9.5.4 The Vice President, RCSD stated in a presentation to the commission: "Medical costs are escalating. This is an area we're still not entirely satisfied with but we have made some progress. We have systematically taken every health care provider and started to put in place fee schedules that are understood by both parties, so that would include the BCMA, the Physiotherapy Association, the Chiropractic Group. But we've got the prosthetic suppliers, where ... with the exception of the hearing providers there are no fee by individual provider for those particular services." (WP25, p.86)

9.5.5 93% of GPs and 96% of specialists bill the Board for less than $8,000 per annum which impacts the Board's ability to influence these practitioners.

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

9.6.1 The Salaried Physician's Agreement between the Board and BCMA runs until March 31, 1999. A lengthy and detailed document, it includes discussion of: general conditions, dispute resolution, severance, continuing education, holidays, illness, expenses and salaries. (WP312)

9.6.2 The BCMA submission to the commission states: "Two negotiated agreements exist between the BCMA and the WCB: one for fee-for-service physicians and one for salaried physicians. These agreements are the foundation of the relationship between the WCB and the physicians of British Columbia. The BCMA is recognized by the WCB as the official representative of its members under section 2 of the current agreements." (I-EMA-064, p.5)

9.7 the financial information is subject to verification/audit

There is insufficient data to comment on this criteria to-date.
Hypothesis 10:  THE DIVISION IS PROTECTING ITS ASSETS

CCAF attribute:  11

Evaluation criterion:

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 partially supported by the evidence.

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.

Staff are also an organizational asset both as the means of pursuing the organizations goals and as the repository for its history and culture. The management staff interviewed recognized this. In addition, a number of policies and procedures are in place that are designed to deal with staff orientation, harassment, and professional development.

Information is not always recognized by organizations as a resource that requires management, as an asset that requires protection. There is no evidence of such an awareness within the Medical Services Department.

Research Findings and Evidence

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

10.1.1 Our findings relative to Medical Services assets such as equipment and finances is covered in Part 1 of this report as these assets are covered by corporate level policies.

10.1.2 In an interview, the Director, Medical Services confirmed that in his view, staff are an asset. The Department invests in them through training, and continual medical education. For example: in his view, besides being an opportunity to do more effective claims management, case management “is also a far more satisfying vehicle for people to work within: it values their contribution more; creates a more valuable, professional and rewarding role.” The Department is also providing staff with appropriate equipment. Training and investment in continuing education focuses on operational needs, particularly for front line staff. (WP434, p.5)

10.1.3 In the same interview, the Director noted that "Medical Advisors have their individual professional certification; the Board requires that they be a member of the College of Physicians and Surgeons. “This too is part of asset protection.” (WP434, p5)
10.1.4 The Procedures Manual for Physicians includes discussion of emergency and safety procedures, and human rights policy (harassment). (Sec 1&2, WP311)
Hypothesis 11: THE DIVISION’S AFFAIRS ARE CONDUCTED IN ACCORDANCE WITH LEGISLATED REQUIREMENTS AND WITH EXPECTED STANDARDS OF CONDUCT

CCAF 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 has mixed evidence.

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 is or is not 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 protection 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 (e.g., workers themselves in the Angus Reid surveys, worker advocates such as the BCFL and external physicians). 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.

Research Findings and Evidence

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

11.1.1 The BCFL submission to the commission notes: “Functional pensions are authorized pursuant to Section 23(1) of the Act. Awards can be scheduled, in which case the percentages are
listed in the "meat chart" that is Appendix 4 of the Manual. Non-scheduled awards are calculated by using the AMA Guidelines or on a 'judgement basis’.

Schedules are intended to reflect the average loss of earnings that will result from a specific impairment, and the Board has adopted its own unique schedules for this purpose. There are several problems with this system of scheduled awards.

“For scheduled awards there is no explanation of why, for example, the loss of a middle finger at the PIP joint results in a functional pension of 2.4 percent. Similarly, we do not know why a compression fracture of the cervical spine with up to 50 percent compression should result in a functional impairment of 0-2 percent. Doctors in private practice are at a significant disadvantage when they try to understand the Board's method of calculating impairment because they are not steeped in the "lore" of the Board. This irrationality in the system leads to confusion and cynicism. Other jurisdictions such as Quebec have a system that is at least understandable. For example, it has percentages that relate to specific measurements such as flexion, extension, etc., for the spine.

“A further question is whether the percentages reflect the average expected loss. As work changes, the impact of an impairment on earning capacity may also change. The gap between the scheduled award percentage and the real impact on earnings prompts more frequent use of Section 23(3) loss of earnings awards.”

The BCFL recommends that “Section 23 of the Act be amended to provide for a periodic review and updating of the schedules, and require the Board to provide an explanation of why certain percentages result in certain percentage impairments. Further, Board policy with respect to the measurement of spinal impairment should provide a detailed description of how percentages are arrived at, so workers, their doctors and others can understand how pensions are calculated.”

11.1.2 With respect to Schedule B, the BCFL submission notes: “Schedule B by definition, is Board policy pursuant to Section 6(4) of the Act that establishes a presumption of a work relationship between a disease and a work process. Problems have arisen where Board medical advisors do not accept the presumption established in Schedule B. In these cases the opinion of the individual advisor that the disease is not work-related has the effect of voiding the policy of the Board.”

The BCFL recommends that “Board policy clearly set out the role of Board officials in the adjudication of claims under Schedule B. Specifically, there should be clear direction that the relationship established by the schedule cannot be altered pursuant to claims or appeal decisions pursuant to Section 6(3).” (BCFL Submission p. 17)

11.1.3 The Board’s Policy Priorities for 1998 note that terms of reference for a new Occupational Disease Advisory Committee have been drafted. A call for nominations was due to be issued in late 1997. The review of six outstanding items in Schedule B (bilateral diffuse pleural thickening or fibrosis, firefighters' heart injury or disease, respiratory irritation, bursitis,
tenosynovitis/tendinitis and vascular disturbances of the extremities) will now be completed with the new committee playing a key role in advising in the process. Consideration will be given to the request to add brain cancer amongst firefighters to Schedule B after work on the 6 outstanding items is complete. (WP114, p.13)

11.1.4 Another issue related to the Act is spelled out in the BCFL submission to the commission: "As a result of recent litigation there is a question whether a doctor who is also an employee under the Act can be sued civilly for negligence. The result is that there is doubt whether workers who suffer harm from such doctors are in a less favourable legal position than other patients. In our view, it is unlikely that the Legislature ever intended the subrogation of legal actions to the WCB to interfere in the liability relationship between physician and patient. Rather than wait for the outcome of this litigation there is a need for a legislative solution."

The BCFL recommends that “the Act be amended to make clear that doctors or other professionals who are also employees under the Act are also subject to civil liability in negligence.” (WP447, p.9)

11.1.5 With respect to policy, the BCFL, in its submission, recommends that Board policy be amended “to reflect a strong recognition of the role of chronic pain and its syndromes in the recovery of workers from work-related injuries and diseases and that Board policies adopt the AMA Guide for adjudication of pain.” (WP447, p.8)

11.1.6 The CEU’s submission to the commission raises concern regarding Practice Directive #12 suggesting it contains contradictions to Policy #78.10 regarding direction, supervision and control of treatment. "According to published policy, the Board only has jurisdiction to make suggestions, not to control treatment. It appears the administration is amending Policy 78.10 without actually overtly acknowledging that it is doing so." (p. 11)

"This Practice Directive creates a "Continuum of Care" model based on preferred providers. One of the cornerstones of individual rights and freedoms in a democracy is the right to make choices in the selection of personal physicians and follow any treatment program outline by that physician. It appears that the "Continuum of Care" model ignores injured workers' rights around choice in the area of treatment. This immediately sets up an increased adversarial relationship between the worker, the attending physician, and the Board." (p. 12)

11.1.7 With respect to conduct and ethics, the Director, Medical Services in an interview noted that "College membership provides a code of conduct for Medical Advisors. Nurse Advisors are required to be part of RNABC. These organizations define the ethical standards for the professional body; licenses of both MA and NA are dependent upon meeting the requirements of the respective body, and employment by the Board is dependent upon having membership in their respective body. The Board also has its own code of conduct for staff." (WP434, p.5)

11.1.8 The Orientation Manual for WCB Physicians states: "All WCB physicians are licensed by the College of Physicians and Surgeons of B.C. and are subject to the ethical and professional standards of this body. CME standards equivalent to those expected of members of the
College of Family Physicians of Canada are required of Board physicians.” An internal peer review program assesses quality of documentation and provides opportunity for individual concurrent analysis and learning. (WP309, Sec.5)

11.1.9 With respect to privacy issues, the Procedures Manual for Physicians discusses FIPPA requirements with regard to the collection and release of information. (WP311, Sec.3)

The Attending Physician's Handbook discusses the Board's expectations regarding reporting and confidential information. (pp. 9 and 13)

Practice Directive #8, Disclosure of personal information also relates. "On June 11, 1996 the Panel of Administrators approved amendments to the Rehabilitation Services and Claims Manual to implement recommendations by the Information and Privacy Commissioner concerning the Board's practices with respect to disclosure of personal information about workers to employers. The amendments became effective July 1, 1996." (WP152, Chap.8, p.1)

11.1.10 The WCB Medical Advisory Committee Terms of Reference (1997) state: "The physician Committee members will remain objective, impartial and independent and will abide by the Principles of Ethical Behaviour as stated by the Canadian Medical Association Code of Ethics." (WP313, p.2)

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

11.2.1 In the Orientation tutorials, physicians are advised to "attempt at all times to maintain professional neutrality (avoid investigator bias)." (WP309, Sec.1)

11.2.2 Community-based physicians have expressed frustration with WCB doctors. They perceive that their opinions are dismissed because they are not board doctors. Also that referrals are not always followed up and that the Board is not necessarily a patient advocate. (WP252, p.20)

11.2.3 Clients have charged that Board Doctors are insensitive to cultural and language differences. Also that Board doctors are not advocating for clients. (WP252, p.20-21)

11.2.4 As noted under Hypothesis 6 above, the BCFL submission to the commission documents a common complaint of workers, that Board medical advisors are insensitive and distrusting and sometimes not as competent in a particular specialty as their own physicians. (WP447, p.4-5)

11.2.5 The Director, Medical Services attempted to deal with this issue during hearings of the commission.

In response to the question of how to deal with conflicts in medical opinion, he responded that the conflict is not so much over the choice of physician as over the choice of treatment,
especially when decisions need to be made quickly (rather than post appeal). “In the past, the WCB was overly conservative.” (WP484, p.4)

Another question concerned medical care: “In medical care of injured workers we see a number of different medical applications – the GP, the specialist, the chiropractor, the Board medical advisor, the Board outside consultants and so on. I would like to talk about how we deal with the opinions of all these professionals. Typically a GP will give an opinion and then a Board medical advisor, who hasn't seen the client, will give another opinion and somehow Board medical advisor's opinion prevails. Can you give us some explanation of how medical opinions are weighed within the Board, assuming that they are of equivalent detail and expertise?”

The Director responded: “I think that the historic system would see a situation where the Board medical advisor would be reviewing the file and possibly also examining the client at the 12, 14, 16 or 20 week-point and at this point there could well be, if you will, some hardening of positions and attitudes towards what has worked and not worked thus far. In our ideal world of case management we see a lot of that changing because the Board's medical advisor or nurse advisor, in some cases, will be involved in discussions about care and the ongoing process a lot earlier on. I think it will shift the balance significantly and take away a lot of the adversarial stance that we have now.” (WP472)

11.2.6 In a discussion on the ARCON/EPP Project, the EPP Policy and Procedures Binder notes: In consultation with external stakeholders, the WCB has identified a number of issues relating to the existing pension review process, including:

- the length of time required to reach a pension decision;
- access to service delivery in geographic areas outside of the Lower Mainland;
- inconsistency of PFI evaluations; and,
- the perceived bias of the WCB staff conducting the PFI evaluations.

In response to these issues, the WCB initiated the ARCON/EPP Project, incorporating ARCON impairment evaluation tools and software, standard protocols and procedures, and new workflows, all of which are designed to streamline the evaluation process for permanent functional impairment. The objective of this project is to determine whether the WCB can obtain consistent, repeatable, and timely PFI evaluations using EPPs. Together with the EPPs the project team will test the new processes during the four-month EPP Project. During the project, the EPPs conducting these evaluations will be given the opportunity to provide feedback on the protocols and procedures, as well as collaborate on any improvements to the overall strategy for performing PFI evaluations. At the end of the project, the WCB anticipates the development of a business model and business case to support further expansion of the use of the ARCON tools and EPPs in locations throughout B.C.” (WP325, p.2)
11.2.7 The BCFL submission to the commission avers that "The current system for compensating workers with allergies and sensitivities to substance at work is not fair or appropriate. A worker who develops an allergy or sensitivity from exposure has it only because of the exposure at work and often cannot return to work. The same person will have lost some physical capacity but is only symptomatic while being exposed to the particular substance that causes the sensitivity or allergy. Since the symptoms are present only when the worker is exposed to the substance in question, the Board does not consider the worker to suffer from a disability when not exposed to the agent. That person may be entitled to retraining from the Board but he/she is not entitled to a pension because, according to the Board, there is no permanent disability."

The BCFL recommends that “the Act and/or Board policy be amended to recognize the lost earning capacity resulting from the need to avoid exposure and provide for a pension in cases of work-related sensitivities and allergies." (WP447, p.14-15)

11.2.8 The same BCFL submission notes that: "Schedule B provides for a presumption for tendonitis and tenosynovitis where the body motion is 'unaccustomed and repetitive' (Item 13). However, when this addition to the Schedule was being considered, the Board's own medical department recommended that the motion requirement should be 'unaccustomed or repetitive'. This recommendation was overruled by the then governing body of the Board. This essentially political definition of entitlement under the Schedule has obviously made it more difficult for workers to obtain a fair adjudication or their claims.”

The BCFL asks the Commission to recommend that Item 13 be amended to read as originally recommended by Board staff: 'unaccustomed or repetitive.". (WP447, p.16)

11.2.9 Again, the BCFL submission notes: "Section 6(1) [of the Act] as currently written creates real injustice because of the phrase 'disabled at the work at which he was employed'. This problem is well-defined in Appeal Division decision #92-1314 (this is unreported but the Section 96(4) president's referral has some related information and is reported at 9 WCR 269). The problem here is that a worker can be disabled from a disease that is unquestionably related to his/her work but, because a claim is made after retirement, a functional pension is not payable because of the above wording. Moreover, the Board is now interpreting this to mean that if a worker returns to his regular employment at pre-injury earnings, the worker is not entitled to a disability award based on the functional impairment.”

The BCFL recommends that “the Act be amended to make entitlement to benefits for occupational disease the same as entitlement for personal injury.” (WP447, p.16-17)

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

11.3.1 In his 1993 Address to the Medical Advisers Meeting, J. Dorsey, then Chairman of the Board of Governors, commented that "some doctors’ opinions are predictable, depending on
whether they are pro worker, or pro employer. This is unfortunately reinforced by the adversarial nature of the appeal process. Some Board physicians’ opinions are discounted by the community and the Medical Review Panel." (WP214, p.5)

11.3.2 The 1996 Administrative Inventory commented: "Workers and others are often surprised and angry at an impairment rating that they judge as low. In particular, if they suffer from severe pain it may be difficult — or impossible — to explain why an impairment is rated at only a small amount, and the worker believes that his/her condition is a severe one. Since treating doctors do not rate a worker's functional impairment, they may provide poor advice to a worker as to what type of impairment rating the worker might expect." (WP18, p.106)

11.3.3 The Inventory stated that "The process of setting the disability award is one of the most difficult, and potentially contentious, aspects of the benefits scheme. The use of schedules allows for some degree of consistency in the rating of permanent functional impairment. Even here, however, it must be recognized that some room exists for Disability Awards Medical Advisers to differ in their ratings, to say nothing of the inherent quality and rationality of the schedules. The core issue, however, is the extraordinary difficulty in identifying the worker's projected earnings capacity...Unlike some other compensation agencies in North America, however, the WCB intends that these decisions will be reassessed periodically. Hence, serious errors in assessing projected earnings losses can be caught by subsequent reappraisal of the worker." (WP18, p.110)

11.3.4 The Inventory also records that the Medical Review Panel "process leads to reversal in about 50 percent of the cases evaluated, and some critics of the WCB allege that this demonstrates an "anti-claimant" attitude on the part of WCB medical staff...Recent efforts in the Department have concentrated on upgrading the technical competence of the staff and encouraging their broader exposure to the community, both through worksite visits and scholarly research and publication." (WP18, p.37)

"The outcomes of the Medical Review Panel process have shown that the appellant has approximately a 50 percent chance of winning at this level. In 1994, the decision being appealed was upheld in 50 percent of the Panels, rejected in 47% of the cases, with some partial agreement in 3 percent of the cases.

“What accounts for the fact that the WCB is found to be wrong in about one half of these medical disputes? In 1994, 61 percent of the cases to a Medical Review Panel were appeals of Appeal Division decisions. Hence, the matter had likely been previously decided by a claims adjudicator, a manager's review, and the Review Board prior to the decision of the Appeal Division. Yet only one half the time was that final decision upheld. Several possible reasons for this outcome could contribute to this record:

• The panel may be using criteria that differ from those used by the WCB and the Review Board. Were this the case, it might result from a lack of familiarity with the standards applied, presumably uniformly, by the WCB's own Medical Advisers."
Conceivably, it might also reflect a stricter, some might say a more harsh approach, by the Board's doctors.

- In some cases, the WCB's Medical Adviser has not examined the worker and may rely on the file only for their decision. Possibly the Medical Adviser's examination is qualitatively different from that given by the Panel. Moreover, the worker's condition may change prior to the Panel.

- It could reflect upon the procedures used to select the specialist. We were told that the worker representatives often know which specialists to select as being more inclined to support an appellant worker.

- Some persons believe that appellants become more adept as they move up the appeal process ladder. That is, workers learn what doctors need to hear in order to accept their appeal.

- Physicians may be reluctant to deny an appeal where there is any evidence that may support the appellant, since they know that their decision is decisive...

“Unfortunately, we are not in a position to judge whether one or more of these or other reasons are related to this seemingly high rate of reversal of Board medical decisions. And perhaps the rate is high simply because only those claimants able to obtain physician certification of the presence of a medical dispute are considered in the rate. When viewed by the standard of all medical decisions made by the WCB reversals in the range of 100-150 cases per year may suggest that there is no underlying problem here.” (WP18, p.80-81)

11.3.5 In an interview, the Vice President RCSD noted that "10,000-12,000 workers go into early active rehab programs e.g. work conditioning, and the pain program. This reduces the number of Short Term Disability referrals. STD disputes from the Review Board have almost dried up. Now disputes focus on entitlement, and, if they are referred to rehab, the quantum of benefits and programming.” (WP498, p.2)

11.3.6 The Director, Medical Services was asked at a commission hearing the following: “Some submissions we heard touched on this very contentious area of how you deal with conflicts of opinion regarding medical treatment. The common fact pattern was where there was a difference of opinion regarding treatment. Very often those kinds of decisions need to be made quickly and are not amenable to a 6 month or a year wait and through an appeal hearing. It could involve different costs in terms of time off work, benefits, consequences if treatment is not successful. What are your thoughts on how that issue should be resolved?

He responded: “In the past the Board has been very conservative in terms of authorization of treatments.” It appears that Dr. Blair's appointment reflects a willingness to take a look at all areas of Board interaction with clients in the medical arena. (WP472)
11.3.7 Another question posed of the Director at the hearings was: “At the end of the day whether you call it two-tier or not the effort is to move injured workers ahead of the line. Are we doing that?”

He replied: “We are attempting to do that. Part of the rationale is that the funding of medical services is not coming out of the general public pool. The employers have a separate pool that is funding services to injured workers and we believe that we should very aggressively be trying to move injured workers through the queues using that separate funding pool. Secondly, I think that the statistics that have impacted on us relative to procuring expedited services are those statistics around people who are off work for long periods and never return and they become advocates of our services or of other social safety nets. I think the impact to injured workers and their families of not receiving expedited treatment and certainly to the employers with respect to costs of not receiving expedited treatments are huge.” (WP472)

11.3.8 1997 Minutes of the WCB Medical Advisory Committee noted concerns about physicians at Abbotsford. "When discussed at SEC, consideration was given to concerns, but it appears nothing has been done to improve the environment. There still appears to be a problem. Action: Ron will talk to physicians in Abbotsford, but pointed out that complaints do not appear to be coming from patients, but rather physicians and perhaps there is a cultural adjustment necessary. Ron will continue to monitor the situation... But clearly expressed, that if we breech people's ability to do their job in a professional way, then we must look at it again." (WP313)

11.3.9 The WCB Medical Advisory Committee also raised the issue of accommodations. "Some doctors at the Board have been assigned 'open cubicles' as their offices. This has occurred at the Abbotsford office. It is felt that such offices compromise the doctor's ability to carry out adequate medical interviews and do not provide the workers with privacy and confidentiality. Correspondence from the College of Physicians and Surgeons states it is the position of the Deputy Registrar that medical interviews should not only be private and confidential but should be perceived to be private and confidential. Such a setting is best provided by a closed office with four walls and a door that can be closed. The Physicians look forward to the administration of the Board taking action to resolve this difficult problem. Ron Buchhorn has assured us that this issue will be addressed in the planning of the Richmond SDL." (WP313)
APPENDIX 6

Detailed Research Findings And Evidence By Hypothesis:
Psychology 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 largely supported by the evidence available to the team.

Objectives are presented in each of the business plans for the department, 1993-1997. They do not always include measurable targets, and they are usually not time bound except in the sense that they are presented as objectives for the current year. Defining what constitutes a goal, objective, and Critical Success Factor for the WCB and tightening up the format of objectives by making them specific, time bound and measurable would enhance the logical integrity of the various planning documents. It would also enable the department to satisfy more completely the criteria for this hypothesis. Critical success factors (CSFs), which are being used in place of objectives, are less rigorous than and do not convey the same sense of commitment as objectives. While some CSF’s include targets (e.g., customer and referral source satisfaction - targeted as not lower than 90%), others are simply "motherhood" statements (e.g., timeliness, keeping waiting lists lower that those of competitors in private practice).

Criteria 1.1, 1.2 and 1.3 and 1.4 are adequately supported. There is no shortage of divisional and departmental planning documents and they meet the criteria for strategic and business plans identified by the Crown Corporation Secretariat. Internal trends identified in planning documents appear to be directly linked to strategic directions established by the RSCD in the 1997 Business Plan, namely client service, case management, operational effectiveness and refine compensation policy and training. The primary measures for the Division are listed but what is not clearly represented in any of the categories are indicators on client clinical outcomes. Dollar budgets are included at the back of the report with forecasts. However, it is not easy to decipher overall departmental costs as they are spread over different categories, (e.g. health care costs, salaries).
Criteria 1.5 is supported by the presence of critical success factors and identified strengths and weaknesses of the department in business plans and an analysis of external business environment.

**Research Findings and Evidence**

**1.1 purpose (mandate, mission, goals/objectives) are clearly stated**

**1.1.1** The Psychology Department works under Sections 21(1) and (6) and Section 56 of the Workers’ Compensation Act. In addition, we are advised that the term ‘personal injury’ is interpreted to include both physical and psychological aspects.

The words ‘psychology’ and ‘psychologist’ do not appear anywhere in the Act. Section 56 governs the duty of physician or practitioner. A ‘physician’ under the Act means a person registered under the *Medical Practitioners Act*; a ‘qualified practitioner’ means a person registered under the *Chiropractors Act*, the *Dentists Act*, the *Naturopaths Act* or the *Podiatrists Act*. There is no definition provided for psychologist.

As such, there does not appear to be a specific and restricting mandate for Psychology Department within the legislation.

**1.1.2** In her 1993 discussion of Psychological Disabilities and Workplace Stress, recorded in the *Workers’ Compensation Reporter*, Connie Munro, then Chief Appeal Commissioner noted that ‘The Act places no apparent limitations on the compensability of "physical-mental", "mental-physical" and "mental-mental" claims. [These three categories are used to distinguish between different types of psychological claims.] Both mental and physical conditions come within the purview of the Act, irrespective of whether they happen suddenly or operate gradually. There is, however, some question as to whether controversial diagnoses fall within the set of injuries and diseases covered by the Act.’ Because of this and the ambiguities in the current policies, the Chief Appeal Commissioner referred the issue of psychological impairments to the governors, stating also, that for reasons given in the analysis ‘it may be very difficult for the Appeal Division to deal consistently with such appeals without the benefit of policy clarification.’ (p.284, 286, WP22)

**1.1.3** In their submission to the commission the Compensation Employees Union added a more detailed commentary on the mental health question. "Adjudicators in Occupational Disease Services, where these [stress] claims are handled, have long been asking for policy clarification with respect to the adjudication principles governing stress 'over time' claims. In 1993, the then Chief Appeal Commissioner, Connie Munro, presented an issue paper about stress, with recommendations to the Board of Governors for consideration. The Appeal Division has ruled that psychological injury cannot be denied on the basis that the Board does not recognize 'stress over time'. The issue needs clarification as workers have an expectation that work related stress is covered. Adjudicators have no policy direction.
The result of this impasse is unfair compensation practice. As of today, this issue remains outstanding." (H-UNI-095)

1.1.4 "Although the British Columbia Act does not preclude any condition from possible recognition as an occupational disease, Board policy may. For example, according to policy, a state of emotional and physical exhaustion due to the stress of work over time (sometimes called "chronic stress") is neither compensable as an injury nor as an occupational disease. It is not compensable as an injury because it is not traumatically-induced and it is not compensable as an occupational disease because the Board does not recognize any psychological or emotional conditions as occupational diseases. However, in a paper on psychological stress, the former Chief Appeal Commissioner reiterated that policy cannot restrict legislation and concluded that the Act, as presently drafted, may be sufficiently broad to encompass chronic stress." (p. 11, WP154)

1.1.5 Psychological services include psychological, psycho-vocational and neuropsychological assessments for injured workers, case and disability management consultation, crisis intervention, group aptitude testing, training, research and education. (p.4 WP1)

Board psychologists have both a medico-legal and a counselling role.

The medico-legal role is as follows:

- “The role of the psychologist in medico-legal assessment is to provide an impartial and objective clinical opinion on the nature and severity of the worker's psychological reaction to a workplace injury, accident, or event and its relationship to pre-existing functioning and concurrent factors, as well as to provide an opinion on prognosis and recommendations for intervention.” (p. 4, WP379)

- "Psychological assessment should delineate the ways in which permanent psychological impairment is likely to affect an individual's employment and work performance and comment on psychological aspects of an individual's work capacity, as stipulated in the AMA-Guides (Fourth Edition 1994). The employability assessment which considers all involved factors, including permanent psychological impairment, is then performed by the vocational rehabilitation consultant." (p. 13, WP381)

Psychologists are also involved in clinical programs:

- Occupational Rehabilitation
- Medical Rehabilitation
- Interdisciplinary Pain Programs
- Head Injury Unit. (p. 6, WP153)
1.1.6 A mission statement for Psychology Department is quoted in the 1993 Administrative Inventory by Fulton (p.83).

The Psychology Department will serve workers, employers and the WCB by providing accurate psychological diagnostic 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.

This statement is documented in the 1993 Strategic Plan (p. 5, WP373), and in the 1995, 1996 and 1997 Business Plans. (p.3, WP375; p.4, WP376; p.2, WP377)

1.1.7 As the Department has moved into Rehabilitation and Compensation Services Division (RCSD), the overall mission statement for the Division is relevant. The Rehabilitation & Compensation Services, 1997 Business Plan (p.2) includes the following mission statement:

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.

1.1.8 A 1995 document describes the mandate as follows: ‘The Workers’ Compensation Board is to provide for the safety, protection and good health of workers, with the Psychology Department primarily addressing injured workers and their dependents in the course of the commitment to provide rehabilitation and compensation services, as well as vocational training to workers who are injured or suffer from an occupational disease. The Worker’s Compensation Board also delivers services to victims of criminal acts, in part through the programs of the Psychology Department.” (p. 2, WP384)

1.1.9 Objectives for Clinical Evaluation of Permanent Psychological Impairment at WCB are documented to articulate quality standards. (p. 2, WP381)

1.1.10 Objectives are presented in each of the business plans for the department for the years 1993 to 1997. However, they do not always include measurable targets, and they are usually not time bound except in the sense that they are presented as objectives for the current year.

1.1.11 A mission statement for the Psychology Training Program is documented in the Internship Manual. (p.3, WP382a)

1.2 the program makes sense in light of the conditions to which it is intended to respond

1.2.1 The Rehabilitation & Compensation Services, 1998 Draft Business Plan (p.39-40, WP269) records that “The Psychology Department has undertaken a recent analysis of the business environment.
“The external factors considered by the Department included: new health care model, province-wide reductions in health care, public awareness, public and government focus on accountability, demographic changes in the work force, continuing lack of objective measurement of pain and poor definitional clarity, consumer rights movement and university cutbacks.

“Internal factors included growing service demand, early and timely intervention, education and brief therapy for injured workers, Supervised Care and Case Coordination/Disability Management, Psychovocational Testing for multicultural clients, increased accountability, prevention, links with universities and community, Interdisciplinary Team approach, and research and outcome evaluation.”

These internal factors are referred to as trends. Actions for the Department are included in the discussion in the Business Plan. However, time bound, specific statements labeled goals and objectives have not been identified.

1.3 measurable, outcome-focused targets have been established for long-term goals/objectives

1.3.1 In the 1997 Business Plan for RCSD "measurement of the quality and efficiency of services became a major focus" (p.4, WP1). Following this statement a series of measures were described. Many of these were administrative in nature, e.g. the length of a claim, productivity ratios. Customer surveys were also included in this listing. Targets specific to Psychology are not documented.

1.3.2 Critical Success Factors for the Department are included in the 1997 and 1998 RCSD Business Plans. (p.35, WP1; p.42, WP269)

1.4 there is a logical, plausible link between mandate and goals/objectives

1.4.1 The documentation provided to the research team did not include any models to demonstrate the logical relationship between mandate and objectives. Given the lack of a specified role for psychologists in the legislation this is an interesting question.

The actions planned for a specific year are reasonable with respect to the mandate of the RCS Division.

1.5 goals/objectives reflect/are cognizant of the challenges the Division faces

1.5.1 There is data on critical success factors, the strengths and weaknesses of the department and an analysis of the external business environment in the annual business plans. Point 1.2.1 above notes the external and internal factors considered by the Psychology Department in its recent analysis of the business environment.
1.5.2 The 1997 WCB of BC Continuum of Care identified four factors that influence psychology services:

1) increased demand for accountability;
2) growing public awareness of the compensability of psychological issues will increase demand for entitlement by WCB's;
3) demographic changes in workforce and workplace; and
4) challenges for objectively measuring pain. (p. 33, WP1)

From other sources, this last challenge appears linked to the ongoing challenge of determining the cause of psychological disability.
Hypothesis 2: THE DIVISION HAS ESTABLISHED A STRATEGY TO ACHIEVE ITS OBJECTIVES

CCAFF 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 only partially supported by the evidence available to the team.

Criterion 2.1 is adequately supported by the evidence. The remaining criteria have partial evidence. As the Department itself acknowledges, clarification of referral policies would help to ensure that corporate plans and activities are integrated. Current strategies are focused on productivity and efficiency measures; client outcomes are not addressed except for satisfaction.

There is no shortage of planning documents for the Division or the Department. However, there is little consistency between the documents concerning planning terminology. Critical Success Factors are presented very much like objectives in some cases, and as comments or strategies in other cases. Priorities, objectives, strategies and initiatives seem to be used in a variety of contexts. This makes analysis of the logical relationships between the various components challenging. One cannot assume that what appears to be a reasonable evolution is in fact the case. For example, the Divisional objectives and strategies from Compensation Division in 1996 have some common themes with the strategies from RCSD in the 1997 Business Plan.

The researchers were unable to complete analysis of Board policy difficulties regarding psychological impairment and treatment, and of administrative resource issues for example in terms of as information systems support; and confirmation of administrative FTE resources.
Research Findings and Evidence

2.1 intended performance is clearly established through effective planning processes

2.1.1 Rehabilitation and Compensation Services Division initiated strategies to support the 1996 Business Plan designed to transform the WCB. (p.13, WP1) Examples of these are the Case Management system and E-files. General strategies identified in the 1998 Business Plan include E-File and client satisfaction. Psychology-specific initiatives include accreditation of the Internship program; and client and referall source satisfaction survey. (p.45-46, WP269)

2.1.2 Criterion 1.2 above notes the recent analysis undertaken by the Department of its business environment. It also notes that Business Plans do not identify time bound, specific goals and objectives.

2.1.3 The 1998 Business Plan for the RCSD contains budgets and forecasts for the number of new referrals and ongoing cases for the Psychology Department. (p. 42, WP269)

2.1.4 The Psychology Department’s plans meet the requirements set out by BC’s Crown Corporations Secretariat’s Guidelines for crown corporations for the preparation of strategic and business plans. Objectives and actions taken to meet them are documented in the departmental business plans.

2.1.5 Job descriptions for psychometrist (07/94), psychologist (06/93), senior psychologist (06/93), and clinical services director (10/94) exist. They describe the roles and responsibilities for these positions. They appear to be straightforward. (WP388.) There was no evidence regarding any conflict between position descriptions and actual work in the interview notes. There are references to these positions in the manuals.

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

2.2.1 As noted in Section 3.1 below, the purpose behind integrating the Psychology Department into Rehabilitation and Compensation Services was "to provide a more integrated service to its clients and customers, with the key focus on return to work". (p.2, WP1) As part of integration, the directors of the various departments meet regularly and are thus able to keep abreast of changes within the various parts of the Division.

2.2.2 The process adopted for planning ensures to a fairly high degree that the plans for each department, including Psychology, are reviewed by the Vice President — RCSD, the President/CEO and the Chief Financial Officer. This iterative process of setting goals and defining the required activities helps ensure that each department plans within the context of the Board as a whole.
2.2.3 One of the CSF's for the Division is a blueprint to ensure that all strategies and outcomes will be implemented harmoniously and without negative impacts. "This includes understanding other divisions' strategies as well as ensuring that this divisions' strategies and timelines are communicated to other divisions where required." (p.15, WP1) Documentation of this blueprint was requested but was not received by the research team.

2.2.4 In the Division’s 1996 Business Plan (p.23), divisional objectives and strategies are organized into four major categories: client/customer service, financial stability, corporate leadership, community/confidence profile. This reflects the structure laid out in the Board’s April 1996 Strategic Plan. (p.14, WP3) Late in 1996 Psychology joined the Division. The RCSD’s 1997 Business plan does not directly relate to this structure. The new strategies are: client service, case management, operational effectiveness, and compensation policy and training. The relationship between these elements is not described. (p.38, WP1) Similarly, the extracts of the draft 1998 Business Plan for the RSCD do not reflect the original four objectives listed in the organizational strategic plan. (WP 269) There appears to be a lack of a cohesive overview in planning. No explanation is provided for the shift in focus described above.

2.2.5 The Departmental Business plan reflects the changes in the organization as a result of integration with Compensation Services Division.

2.3 management processes are integrated and consistently focused on key aspects of performance

2.3.1 Historically, the Psychology Department, with its direct reporting relationship to the President/CEO appears to have worked relatively independently. Now, as part of the RCSD, it is involved in the Division’s communications loop.

2.3.2 Even as a separate department, a service and quality point stated for Psychology in the Quarterly Report June 1996 was an "emphasis on case/disability management by psychology and the integrated effort towards rehabilitation and return to work". (p. 4) 

2.3.3 Case management, which the Board is in the process of implementing, is “an interdisciplinary team approach to serving injured workers with long-term, complex claims unresolved for four weeks after injury. A case manager ... is assigned to each claim and is responsible for coordinating the talents of medical advisors, vocational rehabilitation consultants, psychologists, nurses, and WCB staff from Prevention and Assessments, where appropriate. This WCB team works closely with the client and his or her employer and attending physician to achieve a safe and early return to work.” (p. 8, WP416)

2.3.4 “Vancouver Centre North [one of the demonstration sites for case management] will be staffed by case managers, vocational rehabilitation consultants, a physician, a nurse, and Prevention staff. Psychology and Assessment staff will work on-site as needed...[The Division is] looking forward to a system that’s fully integrated with other divisions and other projects — like the Data Warehouse and the Preventing Accident Repetition
Project." (p. 8, WP416) The research team found inconsistent evidence about whether a psychologist would be going to Vancouver Centre North.

2.3.5 As part of its disability management thrust, the Board is promoting teams of physicians, occupational therapists, physiotherapists, psychologists, and vocational rehabilitation consultants who will work with patients individually and in groups. “The desired outcome for patients include return to work, improved physical functioning, and self-management of pain." (p.1, WP415)

2.3.6 The Board’s 1997 document WCB’s mandate: To assist and inform notes “A psychiatrist works with a team of occupational and physical therapists, a psychologist, and a vocational counselor to customize a treatment plan for the injured worker. Patients who are unsuccessful in recovering in Work Conditioning can be referred to the Occupational Rehabilitation program. Here, a multidisciplinary team of physicians, psychologists, and occupational and physical therapists strives to identify and overcome barriers to returning to work. Failing that, the injured worker may be referred to the Pain Program, where pain management and coping skills are taught." (p. 1, WP414)

2.3.7 The Third Party Provider Database and Management System— Alignment with WCB Strategic Plan is designed to track third party providers, match them with clients and track some outcomes. It is intended to improve client service and increase management effectiveness. (p.14, WP360)

2.3.8 The Psychology Department does not control the inflow of clients and thus its activity levels: these are dependent on the number and nature of referrals from Compensation Services, the Rehabilitation Centre and other areas of the Board. For example, “If a program assesses the worker as fit for work return and the worker does not return or fails at the return, adjudicative staff will weigh the evidence from all sources and take one of several courses of action”, which may include referral to the Board's Psychology Department “if the potential impact of psychological/post-traumatic factors in the case warrants such a referral.” (p. 4, WP153)

Any policy or practice change in a referring area immediately affects the referral flow to Psychology. The Psychology Department’s 1997 Business Plan states: “There is a need to alleviate existing inconsistencies among individual referral sources with respect to the referrals to Psychology. Clarification (in writing) of the Board's policies, procedures, and practices with respect to referrals to Psychology will result in greater consistency among the referral sources and considerable service improvements. Current Board policies in the area of psychological impairment are at times at odds with existing practices that have developed over the years." (p. 10, WP377)

2.4 the focus at all levels is on intended and actual performance
2.4.1 As noted above, in case management and disability management, the focus of multidisciplinary teams, which include psychologists, is to identify and overcome barriers to returning to work. (p. 1, WP414)

2.4.2 Guidelines for medico-legal assessment stress that their purpose is not simply that of a checklist of standards. “Rather, their purpose is to clarify the principles, roles, objectives, and strategies generally applied in these assessments with a specific delineation of clinical and methodological attention points.” (p. 3, WP379)

2.4.3 As noted above, the Third Party Provider Database and Management System—Alignment with WCB Strategic Plan is intended to improve client service and increase management effectiveness. (p.14, WP360)

2.4.4 "A socially and politically responsive, as well as methodologically sound evaluation process needs to be put in place to complete the analysis using these criteria and provide the basis for decision-making on diagnostic and rehabilitation issues and for strategic planning at the Workers' Compensation Board. Stakeholders' and Governors' consensus on these matters is an essential and opening stage of the process."

2.5 objectives and plans are tailored to meet the mandate within resource allocations

2.5.1 Some of the recent initiatives have as their objective both increased return to work outcomes and reduced administrative and pension expenses. For example, “The Continuum of Care is a program that involves the worker, the employer, the Board, the worker’s attending physician, and health providers in a collaborative effort aimed at the prevention of disability. The Continuum is in keeping with the current literature concerning the treatment of soft tissue injury (sprains/strains). The use of this Continuum is designed to increase, on aggregate, Return to Work rates and client satisfaction and to reduce claims duration, disputes and appeals. Early results on these desired outcomes have been sufficiently promising to warrant a province-wide expansion. The Continuum promotes evidence-based decision making concerning treatment and compensation of workers.” (p. 1, WP153)

2.6 adequate funds and staffing are dedicated to the process to ensure success

2.6.1 The 1998 Business Plan for RCSD contains budgets and forecasts for the number of new referrals and ongoing cases for the Psychology Department. (p. 38, WP269)

2.6.2 In 1995 there were a total of 30 psychologists working at the Board. Twelve of these psychologists were in the Department of Psychology, 11 were in the Rehabilitation Centre, 2 serve as one day/week consultants and the remainder serve in administrative positions. Most of these staff were full-time employees and are available to participate in the internship training program. To become a supervisor psychologists must be registered in the Province of British Columbia (which requires doctoral level of training in Psychology) and have at least one year's experience at the setting (two years if doing work in the
medical-legal rotation). The staff is seen to represent a diversity of clinical perspectives and models, with a bias towards a cognitive-behavioral approach. Remarkable diversity is seen in terms of gender, ethnicity and cultural background among the staff. The staff conform to and model the programme's philosophy of a scientist-practitioner approach to clinical training."  (p. 3, WP 382b)

In the 1998 RCSD draft Business Plan, the Department is shown as having 21.6 FTEs. Three new psychologists for Area Offices were approved in 1997 but there were recruitment difficulties. One psychometrist was hired. (p.40, WP269)

2.6.3 In 1995, the Department had an Agency Assessment Report conducted to determine their acceptability for that classification.

"The Department presently has about 60 private sector psychologists under a form of subcontract whereby the Department refers injured workers to these psychologists. A lack of financial flexibility means that the Department has no means to receive remuneration for this referral and brokerage service."  (p. 5, WP383)

2.6.4 Referrals to Psychology appear to have been increasing steadily with some fluctuations caused by administrative decisions. For example a group testing strategy was in place for a while which pushed the number of contacts up. Then the group testing was abandoned which caused a drop in the number of cases seen. Since then individual assessment has been introduced and the numbers are again rising.

2.6.5 The 1998 RCSD draft Business Plan notes that "The Psychology Department tends to operate at maximum capacity with respect to workload requirements given existing staffing levels." (p.41, WP 269)

2.6.6 In the 1997 RCSD Business Plan The Department reported a lack of flexibility in responding to fluctuations in service demands due to staff shortage and recruitment difficulties, as well as a lack of after hour and weekend staff availability. The Department suggested private sector services can be used for some of the clinical issues after hours or on weekends. (p.37, WP1)

2.6.7 The Department identified a lack of sufficient business/administrative support. A part-time business administrator position was recommended in February 1995. In the interim, due to the shortage of managerial resources in Psychology, two Senior Psychologists (CEU members) spend up to 20% of their time on special projects, program development and support. (p.38, WP1) This interim situation continued, being reported again in the draft 1998 RCSD Business Plan. (p.43, WP269)

2.6.8 In the 1998 draft RSCD Business Plan, it is suggested that some of the weakness of the Department such as lack of sufficient business/administrative support will be alleviated with the assistance of the Manager, Medical Services with the administration of the budget and operational needs. (p.43, WP269)
2.6.9 Due to the decentralization of support services for psychologists, there is an anticipated reduction of 1 secretarial staff FTE. (p.41, WP269)

2.6.10 In addition to her departmental duties, the Director of Psychology is also responsible for the Research Services Centre sponsored by WCB-BC and WCB-Alberta research grants. There are two temporary FTEs. (p.40, WP269)

2.6.11 The Department has identified a need to provided decentralized services, particularly to the Kamloops and Abbotsford Offices. The model of decentralized psychological service delivery was successfully piloted in Victoria. However, a significant increase in workload is anticipated as happened in the move of services to Victoria. A decrease in claimant travel costs and improved client service are also anticipated. (p.41, WP269)

2.6.12 The 1993 Administrative Inventory concluded that "The Department has good resources in terms of space, computers, secretarial support, assessment instruments and supplies." (p. xxi, WP252) As noted elsewhere in this report, the recent move of the Department and change in accommodations from offices to cubicles suggests that this finding may no longer apply.

2.7 The plans clearly communicate the standards of service clients (workers, employers) should expect when accessing rehabilitation programs

2.7.1 The documents reviewed clearly state the activities that will be undertaken. For example:

“The Department provides services to workers with chronic pain, head injuries, and those experiencing emotional difficulties as a result of physical injury or emotional trauma in the workplace.” (p.1, WP387)

“The Psychology Department accepts referrals from adjudicators, WCB vocational rehabilitation consultants, WCB medical advisors, and Rehabilitation Centre therapists. Talk to your adjudicator or vocational rehabilitation consultant if you believe you need a referral.” (p. 1, WP387)

2.7.2 These are also described in more complex terms for practitioners. For example: "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 conclusions, and pre-existing factors. Where the biomedical model is largely applicable to individuals with uncomplicated psychological profile in early stages post injury, the systemic and biopsychosocial models become models of choice in later stages of injury and in cases where there exists complicating psychosocial and other clinical factors.” (p. 1, WP396)

2.7.3 Objectives for Clinical Evaluation of Permanent Psychological Impairment at WCB are documented to articulate quality standards. (p. 2, WP381)
2.7.4 Both the Psychology Department’s 1997 Business Plan and the RCSD’s 1998 Business Plan note: “A comprehensive review of policies, procedures, and practices in Compensation Services as they relate to psychological impairment and treatment would greatly assist to alleviate inconsistencies, improve service levels both in Psychology and Compensation Services, and make practices understandable to the stakeholder and clients alike.” (p.42, WP269; p.10, WP377)

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

2.8.1 In our opinion, the organization looks good on paper in that roles and responsibilities are defined, various programs have standards documented, and policies and procedures exist for example, for the Internship Program. The relationship to those outside the department is less clear; for example, referral policies are not clear.

The Department is described in the evidence as ‘flat’. While it is flat, that is not necessarily bad: many organizations are trying to become flatter.

The new reporting structure and the issues it generates also affect this criterion. At this time, we conclude that the Department is in transition and the logic of the reporting structure is still in question.
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

Hypothesis 3 is only partially supported by the evidence available to the team.

Criterion 3.1 has conflicting evidence. Clearly, the autonomy of the Psychology Department has support from both professional standards and ethical guidelines and from the provincial professional association. The successful integration of the department into the new RCSD has not been achieved. Serious consideration should be given as to the appropriateness of the independence claim by the psychologists and the means to improve the current situation for the department. Criterion 3.2 is well supported by the evidence. Criterion 3.3 is generally supported; however the reporting relationship between Rehabilitation Centre psychologists and the Chief Psychologist should be clarified. Criteria 3.4 and 3.5 have partial evidence. It is not possible to conclude at this point that they are adequately supported.

The internal structure of the Psychology Department was not modified during the reorganization in 1996. There is no information regarding whether a review of its organizational structure took place.

Clarification is required as to when if ever managerial resources for the department will be acquired.

Research Findings and Evidence

3.1 rationale for current structure makes sense

3.1.1 Psychology was restructured into the Rehabilitation and Compensation Services Division in the second quarter of 1996 along with the Rehabilitation Centre. "The new structure combines the Vocational, Clinical Rehabilitation, and Medical Services functions to compliment the programs and initiatives being undertaken by those groups such as the focus on early intervention, disability management, the continuum of care, clinical practice protocols and Case Management." (p.2, WP14)
3.1.2 The integration of the program into Rehabilitation and Compensation Services is described in the 1997 Business Plan. The purpose of the reorganization was "to provide a more integrated service to its clients and customers, with the key focus on return to work". (p.2, WP1)

3.1.3 Information provided by the WCB to the commission in 1996 noted that “The Rehabilitation Services Division now consists of the Rehabilitation Centre, the Vocational Rehabilitation Department, the Medical Department, and the Psychology Department. The Division is focused on returning injured or occupationally diseased workers to work through clinical rehabilitation and vocational rehabilitation. One section of the Division, the Medical Services Department, also assists in the assessing of permanent and temporary disability so that Adjudicators in the Compensation Services Division may make reasoned and thorough decisions concerning entitlement to benefits." (p. 29, WP16)

3.1.4 In the draft 1998 RSCD Business Plan, weaknesses of the Department include:

- "lack of sufficient business/administrative support for daily operations; the structure is almost "too flat" and generally unchanged for [the] last 20 years, despite a major growth in the Department." and
- "anticipated adjustment challenges with respect to the decentralization into the SDLs and Area Offices. Particularly an effective resolution of the problem of the provision of emergency services under an SDR-based model." (p.43, WP269)

3.1.5 Prior to its inclusion into RCSD, the Psychology Department reported directly to the President/CEO. This reporting structure was intended as an interim measure. While it worked well, particularly in terms of giving the Department a relatively high profile, some concerns were raised about such a small operational unit reporting directly to the President. This Department, however, is similar in size to Legal Services and Internal Audit, both of which also report to the President, and have multiple cross divisional functions. (p. 4, WP383)

3.1.6 There may have been other advantages to this reporting relationship particularly as the Department provides “services on a demand and collaborative basis to the Prevention Division and the Compensation Services Division”.

3.1.7 In a 1995 interview related to pre-application consultation for the pre-doctoral internship in Clinical Psychology, the then President/CEO did not rule out changes in the administrative structure, but no threat to the current independence of the department was implied. (p. 2, WP384) It would appear from interviews that some at least consider that the Department’s independence has been compromised.

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

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

“In summary, the WCB Psychology Unit is highly regarded for its effectiveness. Its mandate, organizational structure, and autonomy should be retained as it now exists.” (p. 3, WP284)

3.1.9 Some Board interviewees agreed: "Impartially and objectivity should be assured by leaving the Psychology Department separate from other divisions, and making all psychologists responsible to the Psychology Department. A similar arrangement would be appropriate for physicians who, like the psychologists, may find that their ethical and clinical responsibilities may conflict with managerial directives."

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

3.1.11 Another interviewee noted that the “Psychology Department should never have reported to the President/CEO: this happened by circumstance, not plan”. Keeping these functions separated represents “early 90's thinking”, and “is not the way to go in the new world”. “The Psychology Department resisted and is still resisting the change”. However “all disciplines agree with the inter-disciplinary approach underlying case management.”
3.1.12 The Department sought agency status in 1995. "The rationale for an Agency is to improve service delivery and cost effectiveness through increased management flexibilities, in return for agreed-upon levels of performance and results. The Agency model is first and foremost about "culture change" to address cost efficiencies and effectiveness and improve focus on client service. It is an attempt to implement a client-oriented culture change within a single operational/service unit in a more manageable manner, while reducing the risk associated with change at the larger organizational level." (p. 9, WP383)

3.2 roles and responsibilities are clear and well-integrated

3.2.1 The members of the department and their roles are spelled out in the policy/procedure manual. (p. 2, WP387)

3.2.2 "The Director of the Department is responsible for overall efficiency and effectiveness, staffing and management of the emergency response system in the Psychology Department. He/she is also available for clinical emergencies' responding, if none of the psychologists involved is available, and in situations where a decision has to be made. The Director should be immediately notified about any critical incident occurring in the Department involving Psychology staff." (p. 6, WP386a)

3.2.3 Roles and responsibilities for psychometrist, psychologist, senior psychologist, and clinical services director are defined in WP388.

3.2.4 Suggested Roles for on-site Psychologists in Area SDL's are documented. (p. 1, WP364)

3.2.5 Roles and Responsibilities of third party providers of psychological treatment are documented in the clinical guidelines for service providers. (p. 1, WP378)

3.2.6 RFP's for providers clearly document proposal requirements and fees, admission criteria and other standards for service delivery. (p. 2, WP282)

3.2.7 The Mission Statement for the Psychology Training Program is documented in the Internship Manual. (p. 3, WP382a)

3.2.8 Roles of stakeholders in the Psychology Training Program are explained in the Internship manual. (p. 9.1, WP382a)

3.2.9 “The role of the psychologist in medico-legal assessment is to provide an impartial and objective clinical opinion on the nature and severity of the worker's psychological reaction to a workplace injury, accident, or event and its relationship to pre-existing functioning and concurrent factors, as well as to provide an opinion on prognosis and recommendations for intervention.” (p. 4, WP379)

3.2.10 "Psychological assessment should delineate the ways in which permanent psychological impairment is likely to affect an individual's employment and work performance and
comment on psychological aspects of an individual's work capacity, as stipulated in the AMA-Guides (Fourth Edition 1994). The employability assessment which considers all involved factors, including permanent psychological impairment, is then performed by the vocational rehabilitation consultant." (p. 13, WP381)

3.2.11 Referral policies and practice need to be standardized. Responsibility for data capture and documentation needs to be clarified. A comprehensive review of policies for Psychology needs to be conducted to improve service and make practices understandable to staff and clients. (p.35, WP1)

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

3.3.1 As noted above, the roles and responsibilities of the director and staff are spelled out in job descriptions.

3.3.2 The Department has developed the Policy and Procedure Handbook to address clinical service areas. There is also an Emergency Manual and Guidelines for Medico-Legal Assessments in Psychology. "The need still exists to enhance business procedures for support staff." (p.41, WP269) A description of what is meant by enhancement was not available.

3.3.3 An emergency roster is maintained so that coverage for psychological emergencies is available. (p. 1, WP386a)

3.3.4 It is not a secretarial responsibility to ascertain or predict the urgency or severity of the situation. It is also not their responsibility to mediate between the referral source or the worker and the psychologist in question. The role of the secretary ends with the passing of the referral information to the Emergency Psychologist and making the appropriate appointment arrangements, at the psychologist's specific request. (p. 4, WP386a)

3.3.5 The types of decisions made by psychologists and their role in the adjudication process (they submit a clinical opinion) is documented. (p. 3:WP387)

3.3.6 As noted above, the Department has identified an on-going lack of sufficient business/administrative support.

3.3.7 The 1998 draft RCSD Business Plan notes that "clarification is required in the area of gathering collateral information and documentation and cases referred for medico-legal assessment. Clarification is required as to the responsibility for the collection, Compensation Services or Psychology." (p.41, WP269)

3.4 the necessary delegations of authority and decision-making have been made
3.4.1 Given the flat nature of the Department’s structure and its relatively small size, delegation of authority and decision making is not a major concern.

3.4.2 Although the Department is held accountable for its financial performance, it does not have control over several components of its budget which are allocated to the Department on a pre-determined basis (i.e. facilities, informatics, human resources). With a portion of its budget outside of its control, the department is limited in its efforts to control costs and make decisions about the most appropriate allocation of its resources. (p. 5, WP383) Not controlling all of its budget limits both its flexibility to respond to charges as they occur and its administrative and operational efficiency.

3.4.3 All strategic initiatives are funneled through the Information System Review Committee (ISRC), whose voting members are the SEC. This body helps the organization know what is happening in all its parts and assists in setting priorities and allocating resources.” (p. 2, WP433)

3.5 *these responsibilities etc. are communicated and well-understood*

3.5.1 Evidence presented under Hypothesis 4 suggests that responsibilities have been communicated and are understood. This was confirmed through interviewees.

3.5.2 Roles and Responsibilities of third party providers of psychological treatment are documented in the clinical guidelines for service providers. (p. 1, WP378)

3.5.3 Responsibility for data capture and documentation needs to be clarified. (p.10, WP377)
Hypothesis 4: THE DIVISION PROVIDES AN APPROPRIATE WORK ATMOSPHERE

CCAFT attribute: 10

Evaluation criterion:

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 for this hypothesis is mixed.

Prior to integration with the RCSD the Psychology Department appeared to enjoy a highly positive environment. Concerns regarding pay equity and respect for the department have surfaced since the reorganization. Formal planning documents (1997 and 1998 Business Plans) for the RSCD reinforce the perception that the atmosphere in Psychology is appropriate for staff. Relationships in the Psychology Department are reported to be largely positive. Another strength cited in the Business Plans is the positive image of the professionals in the department and their contribution to the research. This is supported by correspondence concerning research and accreditation of the internship programme offered by the department. Despite the "formal claims" of the recent business plans, concerns regarding job security, the value of the department to the WCB and the problems with the reorganization mean that Criterion 4.1 is not supported by the evidence.

Research Findings and Evidence

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

4.1.1 The 1993 Administrative Inventory noted that staff at that time had a good working relationship, disagreement was open and did not result in distancing between individuals or the creation of factions. Staff were able to address ethical concerns with one another. (p.88, WP252)

4.1.2 The 1998 draft RCSD Business Plan states that that situation still obtains: The strengths of the Department include: generally positive interdepartmental and interdivisional relationships, well-functioning relationships and open communication with the stakeholders (e.g., workers and advisors), generally positive labour relations climate, and a focus on organizational effectiveness and interconnectedness at WCB, motivation to contribute to the change process at WCB, highly developed and competitive expertise in the field, positive image in the professional and academic community, record of peer...
reviewed publications and presentations, emphasis on new service delivery paradigms
given changing internal and external environmental factors. (p.43, WP269)

4.1.3 The Department is a cohesive, homogenous group that works well together, within a
democratic management environment. There are no labour relations issues except for the
parity of professional salaries with the private sector. Despite a large amount of change
that has left staff a bit fearful of the future, the cultural climate of the Department remains
positive and staff would welcome the opportunity to capitalize on their entrepreneurial
spirit. The Department is often perceived as operating separately from the rest of WCB,
so much so that staff in other areas of the WCB professed not to have a complete
understanding of what the Department does. However, WCB staff do perceive the
Department as closely linked to the Rehabilitation Centre. (p. 8, WP383)

4.1.4 Interviewees generally confirm this status.

4.1.5 Nevertheless, some interviewees expressed strong dislike and/or concern on a number of
issues.

4.1.6 Regarding their current quarters and being housed in cubicles, interviewees noted that
confidentiality is an important cornerstone of safe and effective rehabilitation care. In their
opinion, cubicles are not an appropriate setting to carry on conversations about medical
and psychological issues due to concerns about confidentiality.

4.1.7 Safety: Psychologists may provide critical incident service (e.g., a gunman, bomb threat,
or impending suicide threat) if they are qualified to do so, if they do not endanger
themselves or others, and if they voluntarily choose to do so. Similarly, psychologists are
not expected to provide psychological services to individuals threatening violence unless
they are qualified to do so, and no harm to others or self is likely to arise from their
involvement. (p. 2, WP386a)

Psychologists are not expected to provide services to individuals who have been identified
as dangerous and threatening violence, as well as to those with offensive weapons.
Regular Threat of Violence Procedures apply when a threat is communicated by the
worker in the course of the involvement with psychologists. The Threat Form needs to be
immediately filled out and the persons, against whom the threat was uttered, notified.
(p.5, WP386a)

“All alarm buttons are installed in all clinicians' offices and connected to the Security Desk
computer monitoring system in the Rehabilitation Centre. In the case of an emergency, a
button needs to be pressed firmly to solicit a response from the Security Desk. A security
staff member will come in several minutes and attend to the emergency situation. The
alarm buttons are detachable, and can be placed in the pocket. It is not advisable, though,
to take them out of the office, as if pressed, they will solicit a response to the location they
are permanently assigned to. Alternately, local 1212 can be called to obtain emergency
service.” (p. 5, WP386a)
The issue for staff is that the interview rooms are now some distance from other staff and alarm buttons may not be adequate in all situations.

4.1.8 Salary levels: “The Psychology Department has difficulty in attracting professional staff because salaries are below those offered in the private sector. This ultimately costs the Department and the WCB in lower productivity, lack of consistency in service delivery to clients, and resources spent on recruitment, training and orientation for new employees. The Department requires additional flexibility in classification of its professional positions.” (p. 7, WP383)

4.1.9 Qualifications and Professionalism: Interviewees also noted: “There needs to be a commitment to recruit qualified experts and the flexibility to pay them accordingly. The Board currently has a policy of recruiting generalists from a particular field rather than individuals with specific training and expertise. This policy is entirely based on financial considerations and not on the value of professionals’ clinical judgement. Many positions are paid less by the Board than by outside agencies or private practice and this contributes to staff turnover and ineffective treatment teams. One young psychologist who was working on contract for the Board moved to a job at a local rehabilitation facility at a salary that is $16,000 higher than the starting salary at the Board. Another Board psychologist is currently considering a similar offer from another local rehabilitation facility. Other psychologists have moved to private practices where the hourly rate is approximately 3-5 times the hourly rate paid to psychologists at the Board.”
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 available to the team.

There is some evidence that the Psychology Department has identified a variety of information requirements. There is also evidence of quality service indicators and caseload indicators being tracked by the department. However, the absence of client outcomes data is a shortcoming identified by the department. Criteria 5.1, 5.2, 5.3, 5.4 have partial evidence but it is not possible to conclude that they are adequately supported.

The evidence for 5.5 and 5.9 is quite strong. It appears that referral trends, caseload indicators, and research support the efforts management is making to utilize resources effectively and inform decision making. However, there are still several information needs that are unmet. Lack of control over IS resources by the department may be partially responsible for the delays in implementing much needed information systems. The division does have a state of the art Third Party Management Information Database unique in the world. This will contribute to the required outcomes data.

There is very limited evidence for criteria 5.6, 5.7, 5.8.
Research Findings and Evidence

5.1 the Division has identified, monitors and reports regularly and accurately the key items that are crucial for accountability (success/failure)

5.1.1 “In 1993, the department initiated the Departmental Quality Service Indicators System to help evaluate outcomes. A pilot Client Satisfaction Survey indicated high levels of approval of the WCB's psychological services. Adjudicators and vocational rehabilitation consultants were also surveyed to find out how the Psychology Department could work more effectively with these key members of the rehabilitation team.” (WP348)

5.1.2 (1995) Caseload Indicators are tracked on a quarterly basis for the Psychology Department. (p. 4, WP367)

5.1.3 The documentation reviewed to-date for the performance measurement project undertaken with the Rydberg-Levy Group does not list any performance indicators specific to the Psychology Department. (WP60, WP61, WP29) There is no evidence in the Rydberg report that directly concerns the Department. (p. 17, WP29)

5.1.4 The Psychology Department has identified the need for a computerized system of appointment scheduling, referral registration, caseload/activity measurement and a client database. A caseload/activity measurement system is being implemented. The IS Department is coordinating a project to develop and pilot a Third Party Providers' Database for implementation in 1997/98. (p.41, WP269)

5.1.5 The Department has identified the need to respond to public and government focus on accountability by monitoring and collecting outcome information, client satisfaction information, and management of third party providers. (p.39, WP269)

5.1.6 The Department has identified the need for staff productivity monitoring. (p.39, WP269)

5.1.7 In correspondence with the commission, the Board advises that the Director/Chief Psychologist researches and evaluates all new screening and assessments tools which are being purchased. The following criteria are used:

1. High validity
2. High reliability
3. Sociodemographically appropriate norms
4. Relevance to problems encountered among the injured worker population.

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

5.2.1 As noted above, caseload indicators are tracked quarterly.
5.2.2 In an interview, the Director, Psychology Department noted that there has been a major snag in collecting statistics for Psychology. The SDL’s do not capture psychology statistics. The clerical staff could do so if there were a management commitment to capture them but it appears that this commitment is not currently present. Also, with constant change, managers do not necessarily know that they are supposed to keep statistics. As a result for the first time this year, statistics have to be estimated. This represents a deterioration in the quality of data the department maintains. (WP435)

5.3 the indicators used actually measure performance and organizational strength (i.e. they are meaningful)

5.3.1 Referrals from the Rehabilitation Centre have increased by 38%. (p. 1, WP366)

5.4 performance information is provided on a timely basis so that results can be used in other management processes (planning, budgeting)

5.4.1 The system used to allow for collection of data; examples include psycho-vocational assessments booking 1994-1997 documented in WP359 (handout from committee information forum Nov. 7, 1997) and referral trends.

5.4.2 The referral trends noted in 1996 were initially observed in 1995 and were therefore anticipated and planned for in 1996 Business Plan. (p. 2, WP370)

5.4.3 "A blueprint of business requirements is being developed that will map out the strategies and initiatives in terms of hardware/software/application/data implications as well as human resource requirements to support the infrastructure." (p.14, WP1) This may be an indication that a strategic information plan exists for the Division. However, it is not explicitly stated.

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

5.5.1 Technological change has been initiated to "provide improved client service and efficiency" in the Division (p.15, WP1).

5.5.2 In January 1996, the Third-Party Provider Database System noted the intent as:

“To deliver a Client/Server system (3-5) users that will:

• provide a more effective method of managing and monitoring service provider referrals (improve/speed up the process of matching claimant needs to service providers)

• provide management statistics on:

• treatment costs

• effectiveness of treatments and service providers
• client usage
• provide a base of information which can be used by that Psychology Department to develop guidelines and criteria for what will be the 'normal' expected treatment goal/outcomes for WCB claimants.
• enable the Department to meet 1996 Business Plan objective #1- Third Party Providers' Data Base and Objective #2, accountability of Third Party Provider under Managed Care. These objectives were not met in 1995 and are key business requirements for 1996.” (p. 6, WP361)

5.5.3 The Department’s quarterly reports for both the second and third quarters of 1995 note: “The Occupational Rehabilitation Program in the Rehabilitation Centre has shifted from the individual to group service delivery mode.” As a result, “OR Psychological Service has implemented two types of groups for injured workers: the psychoeducational groups and pain management groups; significantly increased case load indicators for this program, reflect the new approach.” (p. 1, WP367, p. 1, WP368)

5.5.4 “Total referrals to the Psychology Department in the First Quarter 1996 increased by 3% compared to the First Quarter 1995. The highest increase in referrals was noted in ongoing referrals and amounted to 11%. The referrals from Service Delivery Locations and Area Offices, which constitute the most significant referral group, have increased by 2%. A decrease in group vocational testing referrals continued (13%). There was a slight reduction (7 cases) in the referrals from the Rehabilitation Centre due to the transfer of the Occupational Rehabilitation Program psychologists directly to the Rehabilitation Centre.” (p. 1, WP369)

5.5.5 “The second quarter 1995 showed an overall increase (by 13%) in referrals to the Psychology Department. A significant (38%) increase was noted in ongoing referrals reflective of the integrated care/disability management approach in the Department. The trend towards the decrease in referrals for group psychovocational testing continues but is partly offset by the increase in referrals for individual psychovocational assessments.” (p.1, WP370)

5.5.6 In the Psychology Department, the second quarter 1996 performance indicators showed an overall increase (by 13% compared to the second quarter of 1995) in referrals. A major growth of 38% was noted in ongoing referrals, indicative of increased departmental emphasis on case/disability management, and the integrated effort towards rehabilitation and return to work. New clinical referrals from Service Delivery Locations and Area Offices remained strong and steady (1% increase compared to 1995). A declining demand for group vocational aptitude screening has continued (19% reduction in referrals). This is likely related to (1) the introduction of comprehensive individual psychological assessments as a new service in the Department; (2) the use of privately-based vocational testing services outside of the Lower Mainland; (3) new trends in vocational case management at WCB. Year-to-date performance indicators for 1996 showed an overall 3% increase in referrals to Psychology, arising primarily from the area of ongoing case...
management. The referral trends noted in 1996 were initially observed in 1995 and were therefore anticipated and planned for in 1996 Business Plan. (p. 2, WP370)

5.5.7 A Retrospective Analysis of Routinely Collected Sociodemographic, Claim and Clinical Data., whose authors include the Director of Psychology, notes: "Chronic disability as a result of an occupational related low back injury is a problem with biological, psychological and social aspects (Waddell & Turk, 1992). What remains necessary is the systematic collection and examination of biopsychosocial and systemic factors known to be involved in the disability process. Identification of factors allowing for effective prediction of occupational disability will allow workers' compensation boards to collect clinical, claim and systemic information that is truly relevant for the prediction of disability. Current routinely collected file information does not allow for the building of an effective predictive model of occupational disability; the results of the prospective study to follow this pilot are expected to fill this critical information gap." (p. 58, WP410)

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

5.6.1 Based on our analysis of the evidence described above and on interviews, it would appear that while the Department used to meet this criterion, the case, the change in delivery methods, with psychologists spread among SDLs and the lack of support staff directly for the Department, has led for the first time in a decade to the use of estimates rather than actual figures.

5.7 reports present data/information and analysis that is accurate, reliable, consistent, complete, meaningful, timely, replicable, impartial and that states assumptions used

5.7.1 Record keeping requirements are spelled out e.g. clear communication, opinions are to be identified as such, legible. (p. 2, WP386c)

5.8 reporting is subject to verification/audit

There is insufficient data to comment on this criteria to-date. There are evaluations of satisfaction, by client and by referral sources. Typically adjudicators (referral sources) do provide some feedback on the program. However they are conducted by program representatives not externally and thus objectivity is questionable. There is no data to indicate that this system has ever been audited, or in fact that any of the reporting systems have been verified. As noted by one interviewee: "Any evaluation issue is a problem at the Board, partly due to the CEU. Anything that could even imply anything negative they get warned off."

5.9 performance information is the basis on which decisions are made

5.9.1 According to interviewees, the Department performed well over the four to five years before amalgamation with Compensation Services. It always managed its budget, and
played an innovative role at the Board. For example, the Department had the first strategic plan at the Board. They were second department, after BEEP, to introduce a client satisfaction survey, and they were the first to do this on a systematic basis. The surveys included both clients and referral source and sought details about specific programs, not just general satisfaction. These surveys represented a move away from hearsay to actual data. The methodology employed selected the client sample randomly from all who had received services within a certain time frame. They were phoned at three months after discharge and given a half-hour interview. About 100 persons per year were phoned. A parallel survey contacted the referral source, typically an adjudicator. Thus the Department had two indices and could look at the relationship between them. When results became available, they were reviewed with staff to deal with shortcomings and identify improvements to be made.

5.9.2 Interviewees also described the 3rd party (providers) Management Info Data Base. This process, which the Department has been working on for two years with ISD, matches workers to service providers in their home communities, and evaluates third party services e.g. counseling. There have been some delays, but the product is good. There is apparently no system like it in the world. The system captures data on the worker e.g. treatment required, and on the therapist e.g. language, gender, experience, and then matches to meet the requirements of the worker. The system will allow the Psychology Department to observe trends e.g. where problems occur, average length of treatment. At present, there is nothing comparable in the literature; this approach is ground breaking. It will inform on outcomes, client satisfaction, WCB costs, RTW, reduction in systems, and reduction in disability.
Hypothesis 6: THE DIVISION IS ACHIEVING ITS OBJECTIVES

CCAF attributes: 1 (in part), 3, 4, 5

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

There is adequate evidence to support Hypothesis 6.

Criteria 6.1, 6.2, and 6.3 have solid evidence. It is possible to conclude that they are adequately supported. There is no evidence to-date for criterion 6.4. Department-specific documentation did not highlight any secondary impacts of programs. Despite the lack of evidence to support criterion 6.4 the cumulative evidence for this hypothesis is quite strong. Client satisfaction ratings are consistently high, research leadership is evident, caseloads have grown consistently and reflect an increased appreciation of the need for psychological services to the injured and disabled.

Research Findings and Evidence

6.1 the Division is achieving what is set out to do

6.1.1 Referral and case volumes are as follows:

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>SDL/AO/RC Referrals</td>
<td>857</td>
<td>939</td>
<td>968</td>
<td>950</td>
</tr>
<tr>
<td>Vocational Referrals</td>
<td>371</td>
<td>279</td>
<td>308</td>
<td>200</td>
</tr>
<tr>
<td>Total New Referrals</td>
<td>1228</td>
<td>1218</td>
<td>1276</td>
<td>1155</td>
</tr>
<tr>
<td>Ongoing Cases</td>
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<td>1135</td>
<td>1340</td>
<td>1020</td>
</tr>
<tr>
<td>TOTAL CASELOAD</td>
<td>2203</td>
<td>2353</td>
<td>2616</td>
<td>2170</td>
</tr>
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1 Figure for total new referrals in 1997 is actual, not forecast.

Total incoming referrals for 1993 were 1,413 and 1,442 for 1994.
6.2 the programs/services the Division delivers are relevant

6.2.1 The Psychology Department has moved away from group testing to more individual psychovocational testing. The Department indicates that this allows for a more in-depth and "effective" evaluation. However, the basis of this assertion is not documented. (p.38, WP269)

6.2.2 Declining demand for group vocational aptitude testing is reported in the second quarter in 1996, a 16.2% decline over the same period in 1995. This is reported to be related to: the introduction of comprehensive individual psychological assessments as a new Psychology Department service, the use of private vocational testing services outside the Lower Mainland, and new trends in vocational case management at WCB. (p.9, WP14)

6.2.3 In both the 1997 and the draft 1998 Business Plans, the Psychology Department identifies critical success factors including:

- the implementation of new operational procedures to promote internal consistency and responsiveness to client needs; and

- the implementation of the Guidelines for the Evaluation of Permanent Psychological Impairment which have been approved by experts and by the stakeholder community. (p.36, WP1; p.42, WP269)

6.2.4 The WCB’s Occupational rehabilitation proposal package notes: "The Occupational Rehabilitation Program is an outcome oriented interdisciplinary program. The Occupational Rehabilitation Interdisciplinary Team shall consist of a Physical Therapist and Occupational Therapist for every client served. Where appropriate or when designated by the Workers' Compensation Board, the services of a physician and/or psychologist will be used. ... The ratio of clients on program to psychologist and doctor shall not exceed sixty. For every additional sixty clients on program, or portion thereof, an additional psychologist and doctor must be on staff. The program consists of evaluation and treatment focused on the restoration of physical and behavioral function with an ultimate goal of return to work. The program incorporates physical conditioning, education classes, the performance of real or simulated work tasks and individual medical or psychological support as required." (p.1, WP282)

6.2.5 The literature reviewed generally supports the interdisciplinary approach utilized at the WCB.

6.2.6 The critical incident response coordination “was initiated in 1992 in response to external requests from industry to assist employees affected by a traumatic workplace incident. Whereas a critical incident in the workplace might give rise to a WCB claim for Post-Traumatic Stress Disorder (or other anxiety condition) by the person(s) most directly
affected by it, it was recognized that in many situations other employees were emotionally upset or traumatized by the incident. It was expected that the provision of a critical incident defusing and/or debriefing (CISD) process in the workplace shortly after the incident, particularly involving these other affected individuals, would prevent both the development of more persistent or significant psychological trauma, as well as prevent additional WCB claims, or would in fact prevent any claim at all from arising from the incident.” (p. 2, WP362)

6.3 **the constituencies to which the programs/services are directed judge them to be satisfactory**

6.3.1 Clients’ satisfaction indicate an overall rating of 92%. Industry standards aim for 85%. However information regarding the sample size or frame is not clearly presented. It is impossible to know what percentage of clients were surveyed. (p. 3, WP385) The Director, Psychology Department provided some clarification as noted above.

6.3.2 In 1994, “Ongoing satisfaction surveys were conducted among internal referral sources to evaluate service quality; results indicate that at least 90 percent of those surveyed are satisfied with the quality and timeliness of the service...a psychologist position was introduced on Vancouver Island, eliminating the need to take workers out of Victoria, Nanaimo, and Courtenay for assessment and treatment. Community feedback has been extremely positive.” (p. 23, WP350)

6.3.3 “Client satisfaction survey in the Psychology Department indicates a very high level of satisfaction with the service. Also, annually performed surveys of referral sources (e.g., adjudicators) indicates high to very high levels of satisfaction with the timeliness and quality of psychological service.” (p. 10, WP375)

6.3.4 The submissions to the commission identify some areas of dissatisfaction with services. For example:

- There do not appear to be any special services designed for dealing with first nations people. (p.2, S-ADV-004)

- “Counseling should be made available on how to deal with stress, training and financial management. Psychological effects of injury must be considered, e.g. one claimant lost his fingers and now is afraid to go near saws yet we are told there is nothing we can do for him.” (p. 1, S-ADV-004)

- With respect to John M, an injured worker, a “Board psychologist recently explained that, while he had a task, such as school, he could maintain his focus. Once he had no central focus, he began floundering and losing concentration. This was attributed to his head injury. This was the only psychological assessment he had to this point. Mr. M. has had so many adjudicators, he can't keep track of
them. He has had only one rehabilitation consultant the whole time, and the continuity has been "great." The medical end has been unsatisfactory. They don't seem to coordinate anything with anyone else involved with his claim. When Mr. M. was ordered to report to Duncan for cognitive, psychological tests, his rehabilitation consultant knew nothing about it. Mr. M. claims that the WCB psychologist put a number of false statements in his report, and when it was pointed out, and an independent report was sought, the psychologist 'got real hostile.'” (p. 1, A-INJ-589)

• Another injured worker: “I feel you cannot compare an injured worker's protection of privacy to a Board employee's qualifications. Injured workers are not being paid to make decisions that will affect injured workers financially, physically, and emotionally — Board employees are. Injured workers do not have any choices of insurance companies to apply to — Board members do. An injured worker did not apply for the injury/position hoping that he or she had the right qualifications, an employee at the WCB did. Board employees' qualifications are not remotely as private of violating as the things they have compiled about me, such as my school record, grades 1-12, with which they have taken the time to figure out what group IQ scores I had in grades 1, 3, and 6 and document how many courses in high school were incomplete. Qualifications of Board employees are very relevant to the proper implementation of my claim. My qualification and wages as an electrician are very relevant in the proper evaluation and adjudication of my claim.” (p. 6, L-INJ-413)

The same worker continues: “To cope with the residual effects of my work injury takes everything I have left. I have managed with the huge support of my family, doctors and God. Thanks to the support of a psychologist named Dr. Gary Lee I have managed to fall on the right side of depression, mental and emotional breakdown, and suicide. The Board had recommended and insisted that I be assessed by Dr. Lee in 1992. I complied. In 1993 against Dr. Lee's recommendations and my wishes his services to me were cut off by the WCB. The offices of the Ombudsman and Ministry of Labour and Consumer Services had to get involved before Dr. Lee's services were reinstated. My claims adjudicators and rehabilitation consultants would make statements to me such as: if you didn't lose consciousness how could you have a head injury? The only reason you still think about your accident is because you want to. We've had people hurt far worse than you handle it far better. There is no such thing as post traumatic stress disorder. My claims adjudicator just cut off Dr. Lee's services without investigating all of the medical evidence in my file. She just simply cut off Dr. Lee's services that they had recommended in the first place with no regard whatsoever of the impact it would have on me. When the WCB denies medical coverages, threatens financial ruin, makes inappropriate comments and accuses me of fraudulence this is called secondary wounding according to a report written and published in the Canadian
Practitioner by Dr. Gary Lee called ‘Secondary Traumatization of work related Rehabilitation Clients’”. (p. 8, L-INJ-413)

6.4  the Division is able to identify secondary impacts and eliminate those that are negative, and build upon those that are positive

There is insufficient data to comment on this criteria to-date.
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

Hypothesis 7 is partially supported by the evidence available to date,

Criterion 7.1 is partially supported by the evidence. The data provided is useful but not comprehensive enough to base a strong conclusion on. The same can be said for Criterion 7.2: budgets and forecasts are available but lack of substantiated evidence of the cost of internal vs. external assessments is a concern.

Research Findings and Evidence

7.1 the Division is able to identify costs, inputs and outputs and determine the relationship between them

7.1.1 In the 1998 RSCD Business Plan, two CSF’s stated for Psychology are:

- productivity - retaining clear productivity standards in the Department (already in place) and monitoring service unit costs; any increases in unit costs can only be justified by:
  1) increased service complexity
  2) increased service quality; and

- innovation - promoting service initiatives resulting in heightened consumer outcomes and cost reduction, such as: increased emphasis on cost-effective case management. (p.42, WP269)

7.1.2 The Director of Psychology noted during an interview that whether to use internal or external providers is a business question revolving around costs. Her calculation, prepared for Dale Parker, then President/CEO, of the cost of doing an assessment internally including facilities, utilities, secretarial staff, and other overheads was $700-$800/case, compared with $2,000 externally. Private practices charge $115/hour.
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)

7.2.1 The research team was not provided with evidence related to this criterion. In interviews it was reported, for example, that the service unit cost has been reported as not increasing over time. Psychology appears to have held the line on budgets over time.
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 only partially supported by the evidence available to the team.

Criterion 8.1 is strongly supported by the evidence. Criteria 8.2 and 8.3 have partial evidence. Staffing levels in the Department need to be checked further. These data are from the draft 1998 Business Plan. It is not possible to conclude at this point that they are adequately supported.

Research Findings and Evidence

8.1 the Division has the ability to maintain or improve results

8.1.1 The strengths of the Department include: motivation to contribute to the change process at WCB, highly developed and competitive expertise in the field, and a positive image in the professional and academic community. (p.43, WP269)

8.1.2 As noted in criterion 6.3 above, client satisfaction ratings stand at 92% compared with industry standards of 85%. However information regarding the sample size or frame is not clearly presented. It is impossible to know what percentage of clients were surveyed. (p. 3, WP385)

8.1.3 The Psychology Department’s 1997 Service Quality Survey Results show that in 1997 and 1996, adjudicators’ overall ratings of the Department were very positive, 27 responses were usable N=58. There is no data to indicate the number of adjudicators (the sampling frame) and how they were selected. The results appear to be consistent across the 2 years. (p. 1, WP385)

8.1.4 The WCB Psychology Department handled a 25 percent increase in referrals from WCB claim centres in 1995 and continued to work with a growing number of ongoing cases.
A $100,000 grant was received from the workers' compensation boards across Canada to conduct research on "Prediction of Chronic Occupational Disability: Chronic Pain." (p. 11, WP347)

8.1.5 Board psychologists are conducting research in the field. For example,

- Since none of the published definitions of the Chronic Pain Syndrome fully meets the above requirements, the Board Psychology Department undertook work on the refinement of diagnostic criteria for Chronic Pain Syndrome published in the Fourth Edition of the American Medical Association's Guides for the Evaluation of Permanent Impairment (1993, pages 308-309). Proposed behavioral criteria for Chronic Pain Syndrome are enclosed in the Glossary. Further research on reliability and validity of this construct is underway in the Psychology Department. (p. 4, WP380)

- The 1998 study of Two Phase Treatment of PD and PTSD: Case Study, conducted by Board psychologists, found, for example:

  "Some clinicians advocate selecting a single symptom or disorder as a limited goal for treatment even when a patient presents with a complex traumatic history. This is presumably because they predict that extinction of the original traumatic conditioning is not practical, or because the emotional consequences of the traumatic events are too complex to be addressed during the short-term treatment. Insurance reimbursement and managed care may also play a role in the decision to measure treatment outcome with regard to a single symptom or syndrome, despite of comorbid personality characteristics.

  "... Some may argue that treatment of complex traumatic conditioning arising from childhood abuse is not relevant to psychotherapy in today's managed care environment. However, evidence that adults with histories of childhood abuse are more likely to experience poor outcomes following spinal surgery ... are more likely to experience chronic pain problems in adulthood ... are more likely to engage in self-destructive behaviors ... and are more likely to use alcohol and other drugs ... suggest that managed care organizations would be well-served by reimbursing short-term treatment of the effects of childhood abuse." (p.3-4, 413)

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

8.2.1 As noted in criterion 2.6 above, there are 21.6 FTE's in Psychology. Three new psychologists for area offices were budgeted for and approved in 1997; however the positions have not been filled due to recruitment difficulties. One new psychometrist was hired. (p.40, WP269)
8.2.2 "The Psychology Department tends to operate at maximum capacity with respect to workload requirements given existing staffing levels." (p.41, WP269)

8.2.3 The Department is, however, endeavouring to establish and maintain a competent and reliable supply of external consultants through the establishment of the Third Party Provider Database.

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

8.3.1 “By insisting that major information technology projects meet demanding criteria, and by monitoring projects after implementation, the ISRC ensures that information technology is planned and prioritized to be consistent with the WCB’s corporate strategies and business goals.” (p. 7, WP416)

8.3.2 Again, the Third Party Provider Database, which is designed to match clients and providers, should assist the Department to adapt to changes in demand and competition.
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 only partially supported by the evidence available to the project team.

The Business Plans for the Division do include cost/benefit figures for a variety of initiatives, as well as budget worksheets. However, financial data for the Psychology Department are not identified separately. The department business plan and quarterly reports include financial accounting information. Criterion 9.2 is strongly supported by the evidence; criteria 9.1, 9.3, and 9.4 are partially supported by the evidence; criteria 9.5, 9.6 and 9.7 have no evidence and it is not possible to conclude at this point that they are adequately supported. Although over half of the criteria are supported by the evidence, the strength of the conclusions are nevertheless still somewhat limited. Financial records are maintained and fiscal management practices are obviously in place with respect to the annual budgeting cycle. However, some costs are not under the control of the department (e.g. IS and human resources). Service unit costs are not clearly detailed in the reports available to the team. There is no evidence that financial information is subject to audit, although this may very well be the case.

Research Findings and Evidence

9.1 the Division has set financial objectives


9.1.2 The 1993 Detailed budget expense sheet includes financial costs in a summary statement. Annual Budgets, actual expenditures, projections and estimates are included. In 1992
salaries made up 47.3% of the budget. The next budget cost centre was for equipment at 36.7%. (p. 1, WP365a)

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)

9.2.1 As noted above, productivity, retaining clear productivity standards, monitoring service unit costs, promoting service initiatives that result in better outcomes at reduced costs and an increased emphasis on cost-effective case management are CSF’s set for the Department in the 1998 RSCD Business Plan.

9.2.2 Measurement of performance is based on salaries and administration expenses as well as capital costs. Caseloads impact the budget directly. Managed care is not a feature of this kind of fiscal reporting. Thus we conclude that the "true costs" of services remains a matter for investigation.

9.2.3 Referrals dictate caseload which has a direct impact on budgets. “Reduction in referrals due to transfer of Cost Centre 8500 to the Rehabilitation Centre.” (p. 16, WP370)

9.2.4 The Psychology Department’s 1995 Business Plan notes that "... the number of new cases served by the Department has more than doubled in the last four years. The service unit costs per client have been, however, either decreasing in the last years or kept constant." (p. 1, WP375) The research team notes that data provided on resources over the last three years shows the number of clients is steady or declining slightly. (See Hypothesis 6)

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

9.3.1 The research team was not provided with evidence relating to this criterion.

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

9.4.1 The Department’s 1995 Business Plan states: “Various budget reduction options in Psychology, though decreasing the actual costs to the Psychology Department, will likely result in cost increases in the Compensation Services, Health Care Benefits Department, as cases not served by the WCB Psychology staff will need to be referred to a private practice. Due to a significant cost-differential between institutional psychology practice and private practice, coupled with major case coordination and standards problems inherent in utilization of private sector resources of assessment and consultation purposes, all Psychology budget reduction options are questionable from a financial standpoint.” (p. 3, WP375)

9.5 the Division takes the steps necessary to address any variances identified
9.5.1 There is insufficient data to comment on this criterion to-date.

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

9.6.1 There is insufficient data to comment on this criterion to-date.

9.7 *the financial information is subject to verification/audit*

There is insufficient data to comment on this criterion to-date.
Hypothesis 10: THE DIVISION IS PROTECTING ITS ASSETS

CCAF attribute: 11

Evaluation criterion:

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

Evidence for this hypothesis is mixed.

Research Findings and Evidence

10.1 Some of the evidence supporting this criterion is Division-wide or Board-wide and is recorded in Part 1 of this report.

10.2 The Director, Psychology Department noted in an interview that staff are an asset. The Board is very careful regarding security, particularly because psychologists sometimes deal with potentially dangerous patients. All offices have emergency panic buttons. Staff including all secretaries, are trained in emergency response. “There is lots of discussion” among staff regarding procedures. There are emergency guidelines e.g. for violent, suicidal, psycho-emergency clients. One of the psychologists is involved in the Critical Incident Response system. With respect to employees, there is a selection of service providers in workplace to debrief staff, to prevent PTSD.

10.3 "We would like to add that one of the strengths of the Internship Program is that it exposes future psychologists to two forces that may have a significant impact upon their professional activities over the next several years- the increased popularity of managed care and the move towards program-based service delivery. Both of these forces are shaping the way in which WCB psychologists carry out their professional work, and may have a significant impact for our interns as they move into either salaried positions, or private practice in which they serve as third-party service providers to health care organizations." (p. 10, WP417)

10.4 "The Program has clearly adopted a Scientist-Practitioner model of training. This model was articulated consistently by the staff we interviewed, and is viewed as foundational to the work that psychologists do in this setting. The descriptive literature for the program is clear and accurate in regards to its model and what interns can expect here. Further, the internship manual clearly describes the program and its major rotation, and is available as a resource for interns during their tenure in the Program.” (p. 5, WP382b)
10.5 Implementation of PRIME, the computerized third party management system, is due in March 1998. (p. 54, WP269) This will assist the Department safeguard its external supply sources.

10.6 On the negative side, some interviewees told us that, in their opinion, “there does not appear to be any regard for professional acumen and little understanding of how to utilize professionals within the system. The Board has announced the intention to reduce the number of psychologists, through attrition, and has cut one position from the Psychology Department to date. This appears to indicate a lack of regard for professionals or perhaps an inability to use the resources represented by psychologists and the Psychology Department. One psychologist was told directly that his experience and additional training made him a less attractive candidate for a psychologist position in the Rehabilitation Centre. It is our opinion that respect for workers dictates the recruitment and retention of highly qualified professionals. Respect for workers also dictates appropriate attention to professional development and proper utilization of the skills of professionals employed by the Board.”
Hypothesis 11: THE DIVISION’S AFFAIRS ARE CONDUCTED IN ACCORDANCE WITH LEGISLATED REQUIREMENTS AND WITH EXPECTED STANDARDS OF CONDUCT

CCAF 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 adequately supported by the evidence.

All three criteria are supported by the evidence. Detailed entries for criterion 11.2 are cited in Hypothesis 6, criterion 6.3 and are not repeated here. Two submissions to the commission (cited in criterion 6.3) raise questions about the sensitivity of the WCB to clients. One submission raises questions regarding First Nations Peoples receiving culturally appropriate support but it is not aimed directly at the Psychology Department. Appeals typically are not driven by dissatisfaction with the psychological assessment service. There was a strong criticism of the psychologist involved in one case. However this is no basis to warrant dismissing the rest of the evidence regarding the quality of services offered by the Psychology Department.

Research Findings and Evidence

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

11.1.1 The Psychology Department works under Sections 21(1) and (6) and Section 56 of the Workers’ Compensation Act. In addition, we are advised that the term ‘personal injury’ is interpreted to include both physical and psychological aspects.

   The words ‘psychology’ and ‘psychologist’ do not appear anywhere in the Act. Section 56 governs the duty of physician or practitioner. There is no definition provided for psychologist.

   The lack of a definition for psychologists under the Act and the very broad terms for personal injury mean that there is nothing specific to comply with.

11.1.2 Interviewees advised that compliance with the respective code of conduct is a prerequisite for psychologists to become and remain a member of their professional
associations and that good standing with such an organization is a pre-requisite for employment by the Board.

11.1.3 The November 1995 Site Visit report regarding the pre-doctoral internship in clinical psychology noted: “Discussion of various Canadian Psychological Association standards and practices indicated adhere to CPA standards and guidelines. The Workers' Compensation Board is highly sensitive to human rights, in part because of its explicit mandate to serve its ‘shareholders’, workers, their employers, and the community, and, as well, because of very active systems in place whereby it is continually subjected to review by these shareholders. That observation falls short of acknowledging what I would consider to be a caring and sensitive concern for client issues demonstrated by the psychologists and other staff members I interviewed. Departmental seminars are held addressing ethical issues and professional standards. Both supervisors and interns described a focus upon ethical issues when pursuing services for clients.” (p. 3, WP384)

11.1.4 With respect to the internship program, "The pre-accreditation survey by the Canadian and American Psychological Association was conducted in 1995 with positive results for the department's pre-doctoral internship program in psychology. The accreditation survey will be completed in spring 1996." (p. 11, WP347)

11.1.5 The Department’s Psychology Training Program is a member of the Canadian Council of Professional Psychology Programs (CCPPP) and of the Association of Psychology Postdoctoral and Internship Centres (APPIC). (p. 15, WP382a)

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

11.2.1 As noted in criterion 1.1 above, the then Chief Appeal Commissioner referred the issue of psychological impairments to the governors in part because the ambiguities in current policies may make it ‘very difficult for the Appeal Division to deal consistently with such appeals without the benefit of policy clarification.’ (p.284, 286, WP22)

11.2.2 Some four years later, the 1997 Business Plan noted “a need to alleviate existing inconsistencies among individual referral sources to Psychology...Clarification in writing of the Board's policies, procedures, and practices with respect to referrals to Psychology will result in greater consistency among the referral sources and considerable service improvements." (p.35, WP1) “Current Board policies in the area of psychological impairment are at times at odds with existing practices that have developed over the years.” (p.10, WP377) There is a need to standardize referral policies and practice. A comprehensive review of policies for Psychology needs to be conducted in order to improve service and understanding of staff and clients with respect to Psychology practices. (p.35, WP1)

11.2.3 The Psychology Department’s policy and procedure manual contains detailed information sheets for clients that explain what an assessment is, how it is handled, and how results are shared with clients and the WCB. The three information sheets are: Psychological
11.2.4 In the Psychology Department Client Psychological Emergency Procedures information, the criteria for what constitutes a psychological emergency are clearly laid out. (p.1, WP386a)

11.2.5 The Department’s Operational Manual requires confidentiality of records and conversations, and details security practices to ensure sensitive data is not subject to breeches. (p. 3, WP386c)

11.2.6 The 1996 Guidelines for Service Providers documents performance standards for service providers are documented. For example: "The Service Provider is obligated to withdraw from a professional relationship if it is believed that the participation will result in violation of the ethical standards of his/her professional discipline or there is an actual or perceived conflict of interest." (p. 8, WP378)

11.2.7 The same Guidelines also document FIPPA policies: “Under the provincial Freedom of Information and Protection of Privacy Act (FIPPA), all workers are allowed to request copies of information in their file, including all psychological reports related to assessment and treatment. The Psychology Department works closely with the FIPPA coordinators at the WCB since psychological ethics and standards must be recognized and addressed. Most importantly from a clinician's perspective, if a worker requests disclosure of his/her file, it will need to be determined whether such disclosure of the psychological information could reasonably be considered harmful to the individual or others, as there are some exclusions allowable under the FIPPA legislation. Giving the worker feedback on his/her assessment reports in the normal course of service delivery is highly recommended and may be ethically necessary. Feedback offered by the psychologist typically deals with specific clinical issues and recommendations rather than with claims and compensation issues.” (p. 9, WP378)

11.2.8 The Department’s 1996 Guidelines for Medico-Legal Assessment in Psychological Practice in WCB Setting note that “Particular caution and awareness needs to be exercised when assessing minority groups and individuals with limited English skills. Both language and cultural factors may confound assessment results.” (p. 14, WP379)

11.2.9 As noted in criterion 11.1 above, the 1995 Site Visit report for the pre-doctoral internship in clinical psychology stated: “The Worker's Compensation Board is highly sensitive to human rights, in part because of its explicit mandate to serve its 'shareholders', workers, their employers, and the community, and, as well, because of very active systems on place whereby it is continually subjected to review by these shareholders. That observation falls short of acknowledging what I would consider to be a caring and sensitive concern for client issues demonstrated by the psychologists and other staff members I interviewed. Departmental seminars are held addressing ethical issues and professional standards. Both
supervisors and interns described a focus upon ethical issues when pursuing services for clients.” (p. 3, WP384)

11.2.10 The Site Visit report also noted: “There appears to be considerable sensitivity to issues arising from individual differences and cultural backgrounds. The clientele of the Worker’s Compensation Board is strikingly diverse, reflecting the likelihood that many workers will be physically handicapped, the ethnic diversity of the British Columbia population, and its relatively open immigration policies. There are formal provisions to ensure services in a large number of languages, including easily accessed translation services, and training programs for all Worker’s Compensation Board employees enhancing cultural sensitivity. The staff and current interns presently display ethnic diversity. Discussions with supervisors reveal sensitivity to issues of individual differences and cultural diversity and department seminars are scheduled to maintain currency.” (p. 4, WP384)

11.2.11 As noted elsewhere in this report, client satisfaction with the Department is high and above the industry standard. (p. 3, WP385)

11.2.12 Criterion 6.3 cites references from the submissions to the commission that apply to this criterion also.

11.2.13 The College of Psychologists of BC’s Ethical Standards of Psychologists notes: “In the development, publication, and utilization of psychological assessment techniques, psychologists make every effort to promote the welfare and best interests of the client. They guard against the misuse of assessment results. They respect the client's right to know the results, the interpretations made, and the bases for their conclusions and recommendations. Psychologists make every effort to maintain the security of tests and other assessment techniques within limits of legal mandates. They strive to ensure the appropriate use of assessment techniques by others." (p. 5, WP356)

11.2.14 “In 1993, the department implemented an assessment program for clients from diverse ethnic and cultural backgrounds and for those with learning disabilities.” (WP348)

11.2.15 The Department’s 1994 Objectives and Operating Plan cited as one objective: "Increase multicultural awareness in the provision of psychological services to ethnically and culturally diverse WCB clientele through ongoing education. Continued refinement of culturally sensitive vocational assessment program.

Activities:
- WCB Psychology Staff will be involved in selected educational presentations on different cultures, both internally and externally;
- implications of cross-cultural differences for clinical practice in psychology at WCB will be made discussed and necessary adjustments to departmental procedures and practices made." (p. 4, WP374)
11.2.16 Information provided by the Department for the commission in 1998 notes that “in service” on Sikh culture is available to URC’s Claims Officers, Claims Adjudicators, Psychologists and RC therapists. (p. 11, WP417)

11.2.17 Some interviewees felt that "Impartiality and objectivity should be assured by leaving the Psychology Department separate from other divisions, and making all psychologists responsible to the Psychology Department. A similar arrangement would be appropriate for physicians who, like the psychologists, may find that their ethical and clinical responsibilities may conflict with managerial directives."

11.2.18 The Director of Psychology noted that very rarely have cases been appealed for psychological reasons. Of the approximate 2,000 cases appealed each year, 8 cases in the last two years have concerned psychology. In two of these, the opinion of another psychologist was overturned; six were chronic pain cases and involved a misunderstanding with the Review Board. (p. 4, WP435)

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

11.3.1 The Procedures Manual provides direction for management with regard to psychological support for workers appealing claims. (p.6, WP386b)

11.3.2 Guidelines for psychological assessments follow those of the College of Psychologists of BC with respect to ethical and professional standards. (p. 9, WP378)

11.3.3 The Department’s guidelines for assessment in medico-legal practice note that "Particular caution and awareness needs to be exercised when assessing minority groups and individuals with limited English skills. Both language and cultural factors may confound assessment results." (p. 14, WP379)

11.3.4 BCGEU Submission recommends that WCB "ensure that the worker is able to return to work both physically and psychologically." (p. 12, V-UNI-021)

11.3.5 The College of Psychologists of BC’s Ethical Standards of Psychologists notes “Psychologist respect the integrity and protect the welfare of the people and groups with whom they work. When conflicts of interest arise, between clients and psychologists' employing institutions, psychologists clarify the nature and direction of their loyalties and responsibilities and keep all parties informed of their commitments. Psychologists fully inform consumers as to the purpose and nature of an evaluative, treatment, educational, or training procedure, and they freely acknowledge that clients, students, or participants in research have freedom of choice with regard to participation.” (p. 4, WP356)
11.3.6 The Department's Operations Manual states that the psychology-related information and
documentation placed on a claim file:

- must be relevant to the claim and referral in question
- should facilitate communication with other service providers and claims decision-makers on pertinent psychological and psycho-vocational issues
- should limit the possibility of misinterpretation and misuse of psychological data as stipulated by the ethical principles of psychologists.
- should be clear, concise, evidence-based and complete. (p. 1, WP386c)

11.3.7 “Prior to the undertaking of a medico-legal evaluation, the psychologist must obtain the
client’s informed consent to the assessment. In the process, the psychologist ensures the
client’s understanding of the nature and purpose of the assessment, deposition of the
report, limitations of confidentiality, and the implications of refusal to consent to the
assessment.” (p. 16, WP379)

11.3.8 A Workers’ Advisers Fact Sheet notes that “The Workers' Compensation Board (WCB)
will accept certain kinds of claims for psychological conditions. However, they are
usually accepted as part of personal injury claims. This means that the WCB may accept
a claim for a psychological condition that has a 'traumatic' or sudden onset related to
work, or a psychological condition that is the result of an injury or disability related to
work. The WCB will not normally accept a claim for a psychological disorder that has
developed gradually over time. However, you might be able to challenge this policy if
you have a supportive statement from your doctor, psychiatrist, or psychologist linking
your psychological condition to your employment.” (p. 1, WP 164)

11.3.9 Some interviewees told us that in their opinion, "...workers need to be specifically
informed of the types of information that the Board accesses and the amount and types
of data that are accessible to individuals within the Board and organizations outside the
Board. The current blanket permission to access any required information on the WCB
Form 6 (application for compensation) is not adequate with respect to informed
consent."
APPENDIX 7

Detailed Research Findings And Evidence By Hypothesis:
Leslie R. Peterson Rehabilitation Centre

Hypothesis 1: THE DIVISION’S MANDATE IS RELEVANT AND THE DIVISION KNOWS WHAT IT IS SUPPOSED TO BE DOING

CCAФ attributes: 1, 2 (in part)

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 largely supported by the evidence reviewed.

While there is no specific legal requirement for the establishment of a rehabilitation centre, the Rehabilitation Centre was built and operates pursuant to Sections 16, 21 and 56 of the Workers’ Compensation Act. The Rehabilitation Centre has a clearly stated mission, and 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. The planning for the 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. Current plans are less detailed than they were in the past as they are now incorporated in the divisional documents.

In March 1995, the Rehabilitation Centre was accredited by CARF for a three year period for the Chronic Pain Management Programs; Outpatient Vocational and Employment Services; and Vocational Evaluation. The accreditation process included an assessment of Leadership, which includes a) governance, organizational structure and ownership. The requirements were met in these areas.

There is adequate evidence to support all the criteria except 1.4.
Research Findings and Evidence

1.1 purpose (mandate, mission, goals/objectives) are clearly stated

1.1.1 The Rehabilitation Centre was built and operates pursuant to Sections 16, 21 and 56 of the Workers’ Compensation Act. Section 16 relates to the provision of vocational rehabilitation services; Section 21 concerns the provision of medical aid; and Section 56 defines the duty of physician or practitioner. These sections jointly provide the Centre’s mandate.

1.1.2 In a December 1994 presentation to the SEC, Dr. Jessup noted that "(a) Workers' Compensation health care benefits (medical aid) costs continue to rise steeply. (b) At present, the WCB does not appear to have adequate policy to discharge its responsibilities under Section 21 and 57 of the Workers' Compensation Act." (p. 1)

1.1.3 In 1994, the mission statement of the Centre was: "We provide quality rehabilitation to assist employers and injured workers in achieving safe, early, effective return to work." The Centre Policy in 1994 required annual review of the mission statement as part of the planning process. (p. 1.2.1-2, WP106)

1.1.4 The Strategic Plan 1995-2000/Business Plan 1995 for the Leslie R. Peterson Rehabilitation Centre includes in addition to the above mission statement a statement of the Centre's vision, values and strategic principles. (p. 4-8, WP158)

1.1.5 The RCSD 1997 Business Plan (p.2) includes the following mission statement:
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.

1.1.6 In correspondence with the commission, the Board identified the following long-range goals and objectives for the Centre.

Vision Statement:

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

We do this by:

- leading an efficient network of rehabilitation providers
- managing an effective continuum of care
- being a centre of excellent in research, development and teaching
- being a provider of direct clinical service:
  - where a developmental need exists
Statement of Core Values and Beliefs:

- 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.

1.1.6 The SEC determined an overall strategic plan for rehabilitation at its January 5-7 1995 Planning Retreat. The overall strategies are:

- Implement a coordinated, cost-effective clinical care and rehabilitation system.
- Be outcome-oriented.
- Achieve CARF accreditation standards.
- Form partnerships to achieve more efficient, closer to home services.
- Develop better treatment and rehabilitation through research. (p. 2, WP497)

1.1.7 Rehabilitation Centre policy in 1994 required the production of annual goals and objectives prior to the budget cycle every year. In the Centre Policy Manual, the 1994 Divisional Objectives are included, listing objectives, measurements, strategies, and reporting components. (p. 1.3.1, WP106)

1.1.8 The 1995 Priorities and Objectives were:

- Operate on a full-cost recovery basis by year end.
- Reduce unit cost of services where this will not reduce service quality and effectiveness.
- Increase return-to-work rates in each treatment program by a specified target.
- Maintain overall client satisfaction ratings at the 85% level or higher in all programs.
- Speed referrals and client admissions by aligning information sources with the WCB and external treatment providers.
• Monitor each program’s treatment duration and maintain treatment periods within acceptable levels of cost-effectiveness and quality services. (p. 3, WP118)

1.1.9 The 1996 WCB business plan includes a list of priorities. For rehabilitation the priority is: "provide quality rehabilitation and to assist employers and injured workers in achieving safe, early, effective return to work." (WP3)

1.1.10 The Centre’s 1994-99 Strategic Plan noted that "Currently, the Board's approach to rehabilitation is unfocused with service delivery fragmented along divisional lines. Vocational Rehabilitation, under the umbrella of the division whose primary business is paying compensation, is in a separate "world" from clinical rehabilitation. Case management is scant, and early intervention procedures are not well developed. Further, the Board is late in developing effective policies and procedures for working effectively with external providers of rehabilitation programs." (p. 6, WP159)

1.1.11 The 1995 Operational Review of the Support Services Area noted that "The senior Management have a well documented and comprehensive strategic direction and business plan for the Centre and appear to have initiated the implementation of many projects to support these plans. Yet, the Support Services area has not developed annual objectives to mirror the Centre's strategy. " (p. 7, WP156)

1.1.12 In March 1995, the Rehabilitation Centre was accredited by CARF for a three year period for the Chronic Pain Management Programs; Outpatient Vocational and Employment Services; and Vocational Evaluation. The accreditation process included an assessment of Leadership, which includes a) governance, organizational structure and ownership. The requirements were met in these areas.

1.2 the program makes sense in light of the conditions to which it is intended to respond

1.2.1 In the draft 1998 Business Plan, the Centre's business environment has been analyzed.

External factors affecting the Centre are listed as: new work environments that will bring a change in the types of injuries/conditions the Centre faces; demand for more accountability as public sector services are restructured, resources are redirected and the public becomes more aware of Freedom of Information and Protection of Privacy (FIPP) rights; technology that can improve information capture and communication about clients will become practical and more economical to implement; cultural diversity, average education level and average age will increase; increasing emphasis on provision of health services "closer to home"; in response, the range and number of private rehabilitation providers will increase in many parts of the province; through the implementation of the corporate strategic plan, the Centre and the other Divisions will function in a more synergistic manner; and a positive public perception of the WCB as a whole will take time to develop. (p.26-28, WP269)
Internal factors documented included: return to work becoming a more important corporate goal; the WCB becoming more client-focussed; and the Board's evolving rehabilitation strategy (i.e. establishing disability management and integrated care supervision). (p. 28, WP269)

1.2.2 The Centre's 1995-1999 Strategic Plan was based on more than a dozen sources of environmental and stakeholder information. (p. 15, WP158)

1.2.3 The RCSD 1996 Business Plan notes that "Over the last year there has been a significant transformation internally at the WCB. This change is being primarily driven by our clients, and the general public's expectation of high service delivery levels and fiscal responsibility in our organization. However, there has been a powerful momentum internally to change the culture of our organization into one that provides fair and efficient service in a cost effective manner in an environment that is thought of in a positive way, by both external parties and by ourselves." (p. 21, WP300)

1.2.4 In correspondence with the commission, the Board provided the following information regarding eligibility for rehabilitation at the Rehabilitation Centre.

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

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

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

These internal programs has been the development of a formal network of external providers offering services consistent with descriptions contained in comprehensive manuals describing patient population, staffing, treatment strategies, reporting and remuneration.

The Board concludes: ‘The decision as to who goes to what program is thus preorganized.’ The Board also implies that its current approach toward eligibility is supported by current literature and research.
1.3 *measurable, outcome-focused targets have been established for long-term goals/objectives*

1.3.1 In the 1995 Corporate Business Plan, the Rehabilitation Priority was that the quality and outcomes of rehabilitation would meet or exceed international standards for professional rehabilitation and cost effectiveness. Strategy #1 under this priority was that all rehabilitation activities would become outcome-oriented. Actions would include regular external benchmarking, conducting post-discharge and in-treatment surveys, and undertaking cost/benefit analyses of selected rehabilitation services. The second strategy was achieving accreditation first for FEU, BEEP and the Hand Unit, and then moving onto other programs. Strategy #3 was forming partnerships for effective treatment closer to home. The final strategy was the development of better treatments and outcomes through research. (p.34-37, WP4)

1.3.2 Again at the corporate level, the 1996 WCB Business Plan lists its first strategy as customer service under the compensation priority. The goal is "To meet or exceed published standards of service for our customers." The actions related to the goal include: e-file, claims registration, PC acquisition, performance management, WCB/MSP, expert systems, case management, quality review program, clinical practice guidelines, policy consultation group, rewrite of the Rehabilitation Services & Claims manual, disability awards focus on fundamentals, and the vocational rehabilitation focus on fundamentals. The results expected are:

- Pay entitled workers within 17 days from the date of injury by 1997
- Raise customer service satisfaction to 85% by 1998
- Increase workers' rate of recovery of their ability to RTW by 10% by 2000
- Increase workers' return to work by 10% by 1998." (p.3, WP328)

We have interpreted these results statements as outcome objectives.

1.3.3 At the divisional level, the draft 1998 Business Plan contains budgets and forecasts for occupancy, discharges, client satisfaction, RTW at discharge, durable RTW, injury to admission (days), and length of stay (days). (p. 30-32, WP269)

1.3.4 Critical Success Factors (CSFs) for the Centre are included in the Divisional 1997 and draft 1998 Plans. (p. 26, WP1, p. 29, WP269)

1.3.5 The 1995 Business Plan for the Centre included policies, objectives, strategies, action programs, action plans, strategic principles, and critical success factors. The definitions and criteria for each of these components is not given. (p. 4, 27, 31-32, WP158)

1.3.6 The Work Conditioning Program policy and procedure manual includes an outcome standards policy (4.50). The policy states that each clinic is expected to meet minimum
performance standards. Any clinic not meeting the standards for two consecutive quarters may be removed from the list of participating clinics.” (p. 1, WP418)

1.3.7 The Memoranda of Agreement and Fee Schedules for Medical Rehabilitation and Occupational Rehabilitation mention outcome measured or focused programs. These are not, however, mentioned in the Memoranda of Agreement for Worksite Reintegration and Work Conditioning. (WP280)

1.4 there is a logical, plausible link between mandate and goals/objectives

1.4.1 The evidence reviewed by the researchers did not contain any explicit documents such as logic models that would demonstrate the logic underlying the Centre’s structure and its programs. The program evaluation grid samples reviewed showed that they helped operationalize the objectives and define measures; however, no evidence showed the relationships between inputs, processes, outputs and the various levels of outcomes.

1.5 goals/objectives reflect/are cognizant of the challenges the Division faces

1.5.1 A SWOT (strengths, weaknesses, opportunities, threats) analysis for the Centre is included in both the 1997 and 1998 Divisional Business Plans.

1.5.2 The Centre’s 1995 Business Plan included an analysis of the business environment, critical success factors, strengths/weaknesses/opportunities/threats (SWOT), and risk factors. (p. 16, 27, 28, 39, WP158)

1.5.3 The Centre's 1995-1999 Strategic Plan was based on more than a dozen sources of environmental and stakeholder information. (p. 15, WP158)

1.5.4 The 1994 Leslie R. Peterson Client Survey states, "It is evident that a significant minority of clients do not speak English as their main language.” (p. 9, WP453)

1.5.5 In a SEC presentation December 1994: "Due to the distribution of claims durations, caseloads within the WCB will inescapably contain a disproportionate number of long term cases. Case management, and related rehabilitation interventions, must therefore be directed both to reducing duration (e.g. early intervention), and to services consistent with actual caseload.” (p. 1)

1.5.6 PERU conducted an initial needs assessment of elderly amputee clients and reported on it in April 1994. (p. 1) This is an example of the organization collecting information on the conditions it needs to respond to. (p. 1, WP112m3)

1.5.7 In a presentation to the SEC, the then Director noted: "Were the Centre to be detached from the WCB as a for profit agency, the WCB would sustain a reduction in its capacity to evaluate the quality and effectiveness of rehabilitation services, thereby weakening its rehabilitation strategy." (p. 4, WP497)
1.5.8 In his presentation to the commission, Dr. Blair noted that the advantages of a provider network are: specific care, program needs, quality control, performance monitoring, education, clinical practice guidelines, protocol implementation. The disadvantages are: provider resistance, provider availability, possible legislative issues (worker choice and qualified practitioners). (p.20, WP452)

1.5.9 The CARF accreditation process included an assessment of ‘Consumer focus’ in terms of purpose, consumer based planning and accessibility health and safety.
Hypothesis 2: THE DIVISION HAS ESTABLISHED A STRATEGY TO ACHIEVE ITS OBJECTIVES

CCAF attribute: 2 (in part)

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 supported by the evidence made available to the team.

All criteria are met with the exception of 2.6, for which evidence is scant.

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 process. 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.

However, the Centre, as other parts of the Division, could benefit from clarification of the definitions and criteria for each of the components of a strategic and a business plan.

PERU assists programs in making objectives measurable. However, this level of clarity and definition is not always reflected in the planning documents.

The CARF accreditation process included an assessment of Leadership, which includes organizational management. It also examined information analysis and decision-making processes and organizational quality. The requirements were met in these areas.

Research Finding and Evidence

2.1 intended performance is clearly established through effective planning processes

2.1.1 In 1989 the Centre produced a "strategic plan" that was essentially a staffing projection. The next strategic plan found through the research is the 1994-1999 Strategic Plan.
In 1995, Dr. Jessup presented the Centre's 1995-2000 Strategic Plan to the Senior Executive Committee. This document also included the 1995 Business Plan.

2.1.2 In more recent years, the RCSD’s Business Plans have included sections documenting the Centre's historical statistics, business environment analysis, CSFs analysis and projected statistics. (p. 22-27, WP1, 23-32, WP269)

2.1.3 In 1993, the Board of Governors approved the Centre's plan to pursue accreditation. (p. 19, WP18) The 1993 Administrative Inventory indicates that accreditation of the Centre would significantly contribute to putting the programs on an equal footing with other rehabilitation services in the province. (p. xxiv, WP252) The accreditation was awarded in 1995 for a three-year period.

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

- Promote the basic human rights, dignity, health, and safety of the persons served.
- Demonstrate that the persons served are involved in the individual planning, decision-making, and implementing of the services they will receive.
- Provide services that are designed to enhance the independence, self-sufficiency, and productivity of the persons served.
- Provide coordinated, individualized, goal-oriented services leading to desired outcomes." (p. 42, WP100)

2.1.5 In a presentation to the SEC, Dr. Jessup noted that ‘CARF accreditation standards, Section 1.E requires that the Centre "be actively involved in a dynamic, continuous planning process to improve the quality and effectiveness of its services. This planning process should include the collection and analysis of information from a variety of internal and external consumers." CARF standards require that the Centre "develop written plans to take into consideration internal and external assessments and analysis of the environments.. The organizational planning process should involve cooperative inter-agency planning...Information utilized and considered in decision-making should be obtained from:
1. Internal and external consumers,
2. Outcome-based management reports.
3. Information on referrals of persons not accepted into the program
4. Fiscal reports." (p. 1, WP497)
2.1.6 CARF reviewed the Centre’s information analysis and decision making processes, including information management, program evaluation, assessment of program quality and fiscal management. It also examined the Centre’s ability to promote organizational quality in terms of the rights of persons served, intake, orientation, individual planning, and referral exit/discharge and follow-up.

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

2.2.1 Dr. Jessup in a 1995 presentation to the SEC stated that "The Centre's plans are consistent with the WCB's overall rehabilitation strategy." (p. 2, WP497)

"The future development and use of the Rehabilitation Centre will be only one important component in the WCB's overall rehabilitation strategy. The Centre's strategic plan needs to mesh with the Board's corporate plan. Clear allocation of roles and responsibilities is important. Some rehabilitation-related activities are best carried out at a corporate level, while others are appropriate for the Rehabilitation Centre." From the Centre's 1994-1999 Strategic Plan. (p. 8, WP159)

2.2.2 As noted in Hypothesis 1, the SEC determined an overall strategic plan for rehabilitation at its January 5-7 1995 Planning Retreat. (p. 2, WP497) The strategies related directly to the Centre.

2.2.3 The Compensation Services Management Meeting (1995) materials included directions for divisional business planning. Materials included reference to corporate direction, templates for business plan components, and examples of business plan components. Included in the sample were divisional objectives which included both measurement descriptions and strategies. (WP324)

2.2.4 Following its incorporation into the RCSD, the Centre’s plans are included in the Division’s business plans.

2.2.5 In its 1996 Business Plan, divisional objectives and strategies are organized into four major categories: client/customer service, financial stability, corporate leadership, and community/confidence profile. (p.23). This reflects the structure laid out in the Board’s 1996 Strategic Plan. (p.14, WP3) The 1997 Business plan does not directly relate to this structure. The new strategies are: Client Service, Case Management, Operational Effectiveness, and Compensation Policy and Training. The relationship between these elements is not described. (p.38, WP1) Similarly, the extracts of the draft 1998 Business Plan for the RCSD do not reflect the original four objectives listed in the organizational strategic plan. (WP269)

2.2.6 Interviewees told us that Prevention Division sets targets for injury rate and fatalities and projects how their activities may impact these figures. The RCS Division uses these
projections to estimate claims costs, which are then built into the budget. Trends are also examined. (p. 2, WP473)

2.3 management processes are integrated and consistently focused on key aspects of performance

2.3.1 The 1993 Annual Report of the Leslie R. Peterson Rehabilitation Centre states a "Response to the Administrative Inventory. The Rehabilitation Centre concurs with the need to address the administrative inventory's attention points and has begun doing so. In seeking CARF accreditation, the Centre has embarked on systematic development that will strengthen all aspects of its operation. We're working to enhance results in the following four areas:
- Client satisfaction
- Timeliness of service delivery
- Cost-effectiveness
- Service quality
Managing to meet CARF standards has already had an impact on the Centre's operations. (pp.14-15)

2.3.2 The 1994 WCB Annual Report noted that "Increasingly, the work of the Centre is being integrated with that of other WCB divisions to support Board-wide service delivery initiatives in rehabilitation and "managed care." Managed care ensures the best treatment is made available at the right time in the injured worker's recovery, when it can be most effective." (p. 22, WP350)

2.3.3 Nevertheless, a 1995 operational review found that "The majority of the Programs have been operating with independent, nonstandardized processes to complete the same business function." (p. 13, WP156)

2.3.4 This review also found that "While the Programs are obtaining CARF accreditation, in certain instances the strict adherence and interpretation of these guidelines has further contributed to creating more complex and inefficient administrative business processes. This is particularly evident when reviewing the clinical documentation process completed by each Program." (p. 13, WP156)

2.3.5 Attempts are being made to make management processes more integrated. One of the CSF's for the Division is a blueprint to ensure that all strategies and outcomes will be implemented harmoniously and without negative impacts. "This includes understanding other divisions' strategies as well as ensuring that this division's strategies and timelines are communicated to other divisions where required." (p. 15, WP1) Documentation of this blueprint has been requested but not received.

2.3.2 The RCSD’s 1996 Business Plan states: "Members of the Medical Services Department, the Psychology Department, and the Rehabilitation Centre have been developing a "Care
Map" that should integrate existing services within and outside the Board." (p. 61, WP300)

2.3.6 The 1997 Health Care Issues Under the Workers Compensation Act, A Briefing Paper prepared for the commission comments that "The Rehabilitation Centre is currently developing time-based continuum of care models for soft tissue and other types of injuries. The continuum of care models contemplate a series of interventions that are designed to direct injured workers to appropriate rehabilitative programs. These programs focus on the worker’s early recovery and return to work." (p. 13, WP155)

2.4 the focus at all levels is on intended and actual performance

2.4.1 The 1993 Administrative Inventory states that the Rehabilitation Centre's focus should shift from process to outcome.

2.4.2 To maintain involvement of staff in quality management initiatives, the 2nd Quarterly Report for 1996 and subsequent reports note that the staff are sitting on quality management committees in each of the clinical programs, on the RCAC, and on the SIS project team. (p.16, WP14)

2.4.3 Program Evaluation and Research Unit's reports have been made available to the research team. A review of sixty of these reports indicates that the Unit has prepared program evaluation reports by quarter by program; client satisfaction surveys and client feedback questionnaire findings are available for selected programs and varying timeframes.

2.4.4 The draft 1998 Business Plan contains budgets and forecasts for occupancy, discharges, client satisfaction, RTW at discharge, durable RTW, injury to admission (days), and length of stay (days). (p.30-32, WP269)

2.4.5 Documentation for some specific programs demonstrates a performance focus. For example, Work Conditioning Program policies cover client orientation, length of stay, assessment to treatment ratio, program withdrawal, client absenteeism, outcome standards and a client satisfaction questionnaire. (pp. 4.0-4.60:WP281)

2.5 objectives and plans are tailored to meet the mandate within resource allocations

2.5.1 A 1996 report by PERU entitled "Projected Utilization of Occupational Rehabilitation Programs & Savings from Full Use of the Suggest Soft Tissue Care Approach" was designed to answer the question of how many external occupational rehabilitation programs were required and where. Several scenarios were modelled on available data and assumptions. The best scenario showed projected expenditures without a "return on investment". Possible systems changes that could affect this are presented as well as the key factors in increasing savings. (p. 2, 14-16)
2.6 adequate funds and staffing are dedicated to the process to ensure success

2.6.1 In an interview, a Co-Director of the Centre noted that in the clinical ranks, most turnover is experienced in the physiotherapy and occupational therapy areas. This is a source of frustration. Centre staffing is covered by collective agreement. The Board is not competitive in salary areas for these occupation groups; thus he is ‘forced’ to hire new graduates; once these graduates acquire some experience they leave to work for private practice where they earn more. The question for him is “how to get these people to stay.” (p. 6, WP442)

2.6.2 The 1995 Operational Review found that "The more efficiently operating business processes in programs such as FEU, BEEP, and PEP have a higher ratio of clerical support staff to clients. In certain cases, clinical staff have provided more assistance with certain business functions (e.g. booking client appointments, transcription, photocopying, etc.)." (p. 13, WP156)

2.7 the plans clearly communicate the standards of service clients (workers, employers) should expect when accessing rehabilitation programs

2.7.1 Policy 2.11 of the Centre's Policy Manual describes the client's rights and responsibilities. These rights and responsibilities are to be reviewed with each client admitted to the Centre. Injured workers are to be active participants in all aspects of their program. (WP106) Prior to attending the Centre, clients are provided with brochures describing the Centre, the individual program to which they will be admitted, and, if appropriate, the residence.

2.7.2 Policy 2.14 describes the requirements for a client orientation. The Client Orientation Checklist guides the orientation process to ensure that basics such as the reason for orientation and referral, program overviews, facilities, client rights and responsibilities, safety, consent to participate form, release of information form and client goals are covered. (WP106)

2.7.3 Policy 2.40 describes the program description/outline. The program manager is required to maintain a current program description/outline that is provided to customers and referral sources as part of consumer-based planning activities. The program teams are required to integrate the elements of the program outline, develop a schedule for the client and then provide a copy of the program schedule to the client. The program descriptions are to include: the mission statement, program outline, program goals, program objectives, admission criteria, a description of the clients served, the discharge criteria, a process description, program evaluation measurements, and a glossary. (WP106)

2.7.4 In correspondence with the commission, the Board advised that although it does not require external programs to follow the exact procedure it uses, it does require them to perform a complete orientation and involve workers in the decision-making regarding
their care. This standard is ensured by requiring all external programs to get CARF accreditation. Relevant CARF requirements are set out in paragraphs 17.1, 1.a, 17.h and 29.s of Section 1.RP of the 1998 standards.

2.7.5 In 1996 a communication plan for the Centre was developed in conjunction with community relations. It was to be reviewed with senior management and implemented as appropriate. (p. 17, WP14)

2.7.6 The 1994 Client Survey states that, "76% (67/88) of clients felt that the program was clearly explained to them before they began attending and 68% (60/88) felt that their discharge status was clearly explained to them." (p. 9, WP453)

2.7.7 The Rehabilitation and Compensation Division Operating Report for 1996 noted the following: "Establish and monitor service standards for external rehabilitation providers. Develop standards that address client and customer needs. Develop a methodology to monitor external providers to ensure that the standards are being met in a consistent and cost effective manner. Policy and procedure manuals were updated for both Work Conditioning and Interdisciplinary Pain Programs. Continued refinement of PERU's measurement strategies has been augmented by ECRs, a computer program for communicating with external health care providers." (p. 23, WP305)

2.7.8 The Memoranda of agreement for Medical Rehabilitation, Occupational Rehabilitation and Worksite Reintegration programs clearly state admission or referral criteria, and program guidelines/requirements; the first two also specify attendance requirement and length of stay. These items are not included in the Work Conditioning agreement. (WP280)

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

2.8.1 The Centre is developing time-based continuum of care models for soft tissue and other types of injuries. The implementation of these models could lead to reorganization of the WCB’s approach to health care in the affected areas. The models are designed to direct workers to appropriate rehabilitation programs with an eye to early recovery and return to work (RTW). Soft tissue injuries model is the most developed. The continuum of interventions covers a period of 24 weeks from the injury date, with Centre staff contacting workers still on wage loss and referring to specific programs.

2.8.2 “The Continuum of Care is a program that involves the worker, the employer, the Board, the worker’s attending physician, and health providers in a collaborative effort aimed at the prevention of disability. The Continuum is in keeping with the current literature concerning the treatment of soft tissue injury (sprains/strains).” Use of the Continuum is designed to “increase, on aggregate, RTW rates and client satisfaction and to reduce claims duration, disputes and appeals. Early results on these desired outcomes have been sufficiently promising to warrant a province-wide expansion. The Continuum
promotes evidence-based decision making concerning treatment and compensation of workers.” (p. 1, WP153)

2.8.3 The Rehabilitation and Compensation Division 1996 Operating Report notes: "Establish clinical practice protocols and evidence-based practice for rehabilitation. Work with Medical Services in the development of case management protocols utilizing published research and internal program evaluation. All Medical Services protocols are fully consistent with the Rehabilitation Centre's continuum of care." (p. 23, WP305)

2.8.4 A PERU Program Evaluation Report on the Functional Evaluation Unit, First Quarter 1997 notes that the unit “continues to redefine its role and the services it offers this quarter, in light of the Rehabilitation Centre's adaptation of a soft tissue continuum of care model in 1996.” (p. ii, WP471)

2.8.5 In an interview, a Co-director of the Centre noted that the Centre is the biggest in BC. As far as he knows, there is none other like it in the rest of North America, primarily because of the programs and the industrial workshops. Most other centres have to rely on work simulation whereas BC has automotive, welding etc. workshops that more closely resemble the true industrial environment. The Centre is downsizing the workshops as they currently have more than they can use, and because they rely much more on external providers. Also, with earlier intervention, the work conditioning program is returning more people (80%+) to work, and work conditioning is a cheaper intervention. (p. 3, WP441)

2.8.6 However, there are still some concerns. As noted above, the 1995 Operational Review found that the Support Services area had not developed annual objectives to mirror the Centre’s strategy. (p.7, WP156)

2.8.7 There are also some programming concerns. For example, the ASTD Challenge:

- Clients with ASTDs did not do well in the continuum of care.
- There was no standardised and agreed upon approach to treatment or to worksite interventions.
- Rehabilitation assistance for this group became one of the Centre’s seven major initiatives for 1997. (p.11, WP283)

2.8.8 There is also, as Dr. Jessup noted in a 1994 presentation to the SEC presentation, a problem with measuring pain. "Subjective reports of chronic pain are a major and contentious feature of disability for injured workers. ...Pain report is not proportional to gross patho-anatomical causes of pain.” The WCB Chronic Pain Task Force noted that a central issue concerning pain was the difficulty of its "objective" measurement.

“In recent years advanced brain imaging techniques have been used to study pain...Although several neuroimaging and electronic methods for evaluating pain have
been studied, none have emerged as an unequivocal, pure measure of pain sensation.... It is premature to use these methods for clinical or disability award evaluation of injured workers....Policy 39.01 is not contradicted by these findings. The difficulty in applying policy 39.01 is inherent in the functioning of the human nervous system." (pp. 1-2)
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

Conclusion

The evidence for Hypothesis 3 is mixed.

Structural changes in the Division are documented and some rationale for these changes is provided. Management staff report satisfaction with the structure. Evidence to-date suggests that role clarification is an on-going issue at the Centre. Further evidence is required to determine if this is a symptom of staff anxieties during a change process, or if the roles are indeed ambiguously defined.

An Operational Review conducted in 1995 highlights how difficulties in the management of support services can profoundly affect the success of a professional service organization. Issues regarding roles and responsibilities were documented at the time. No follow-up documentation was available to the researchers to confirm that the recommendations of the consultant had been accepted and acted on.

An additional area of responsibility concerns was the conjunction of PERU and ISD. The Operational review is dated, but again no documentation was uncovered that would have 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 this function.

Research Findings and Evidence

3.1 rationale for current structure makes sense

3.1.1 Until 1996, the Director of the Leslie R. Peterson Rehabilitation Centre reported to the Senior Executive Committee which reported to and was chaired by the President/CEO. (p.1.11, WP106)
3.1.2 In 1994, Dr. Jessup presented to SEC a draft Organizational Structure that assumed "a Vice-President of Rehabilitation with a Director, Rehabilitation Centre reporting to the V.P., and three senior managers and their departments reporting to the Director. This would bring the Centre together into a more cohesive unit. In the past each program/department has acted somewhat autonomously." (p. 3-4, WP188)

3.1.3 Detaching the Centre from the WCB and making it a for profit agency also appears to have been discussed by SEC but rejected: "The WCB would sustain a reduction in its capacity to evaluate the quality and effectiveness of rehabilitation services, thereby weakening its rehabilitation strategy. Stakeholders representing the broadest spectrum of interests generally value the Centre positively. Hence, it is an asset to the Board, both in its specific service provision, but also more generally as a positive demonstration of the Board's mandate in action." (p. 4, WP497)

3.1.4 In the second quarter of 1996, the Rehabilitation Centre, along with Psychology, was restructured into the new Rehabilitation Division which reports to the same vice president as Compensation Services Division. "The new structure combines the Vocational, Clinical Rehabilitation, and Medical Services functions to compliment the programs and initiatives being undertaken by those groups such as the focus on early intervention, disability management, the continuum of care, clinical practice protocols and Case Management. The policy, finance and systems areas will now support both operational areas." (p. 2, WP14)

3.1.5 The restructured Division is focused on returning injured or occupationally diseased workers to work through clinical rehabilitation and vocational rehabilitation. (p. 29, WP16)

3.1.6 In an interview one of the Co-Directors of the Centre noted that with the restructuring, the whole Division has moved away from the payment [compensation] model. There has been a real refocusing on what to do to expedite early and safe RTW. For the Division, this is a very different focus from two or so years ago although it had previously been the Centre’s focus. “Now that focus is shared by all of the RCS Division, which could only happen by having the clinical and vocational rehabilitation functions so intimately connected with compensation e.g. through shared meetings and committees.”

The refocussing on rtw as the ultimate goal means that there is now no need to have rehabilitation as a separate division. In his opinion, it would be wrong now to separate them because it would likely mean the compensation side would lose the RTW focus over time. He noted that Alberta and Ontario have the same model that BC currently has. He talks from time to time with his counterpart in Alberta who echoes these views. (p. 1, WP441)

3.1.7 The Centre is run by two equal directors: one concentrates on administrative issues and the other on program and research matters. Co-directorship was an experiment. At first
the co-directors were unsure about the format. However, as one of the co-directors noted in an interview it is working well. Initially he hated the format because the two of them had different backgrounds, agendas etc. But as they became more comfortable with each other it started to work well. They have complementary skills. On the organization chart, some programs report to him and some to the other co-director; in reality, they have mixed the managers so that any one manager reports to one co-director for one program and to the other co-director for another program. The managers probably view the co-directors as interchangeable. “The last two years have been very good, although I would not have recommended the model.” (p. 1, WP441)

3.1.8 An Operational Review in 1995 found that "The Health Record Administrator and Technician positions should be more closely aligned and eventually consolidated with PERU. The role of PERU should be expanded to include utilization management, quality improvement with eventual linkages to program costing. The role of the Health Record Administrator should be reviewed and redefined".

It also recommended that "The senior Management at the Centre will need to provide further direction and resources to assist with implementing the priority recommendations for systems and business process re-engineering. It will be imperative for the Centre to consider implementing a revised organization structure for the Support Services area." (p.16, 19, WP156)

We have not been able to determine whether these recommendations were accepted and acted upon.

3.2 roles and responsibilities are clear and well-integrated

3.2.1 With respect to staff, the 1995-2000 Strategic Plan noted that “continued confusion over role and professional identity may hamper positive growth”. (P.29, WP158)

3.2.2 The 1995 Operational Reviewed noted that "Many of the Support Services staff have requested job description reclassifications and have participated in completing lengthy job evaluation questionnaires. In several cases, the staff have drafted revised job descriptions with higher classifications that reflected new responsibilities delegated by the previous and current Management.” (p. 8, WP156)

3.2.3 To develop management teamwork through clarification of roles, responsibilities and decision-making processes, the management structures were reviewed and revised in the second quarter of 1996. This was listed as an ongoing project at that time. (p. 16, WP14)

3.2.4 In order to integrate Centre programs and services, there are ongoing efforts to develop a common infrastructure for all Rehabilitation Centre (RC) programs through the SIS project. This was documented in the second quarter of 1996. (p. 16, WP14)
3.2.5 Part of the strategy for strengthening the Centre's program teams was the clarification and strengthening of the RCAC's role. At the second quarter of 1996, improved communication between staff and senior Centre management was reported. This was listed as an ongoing item. (p. 17, WP14)

3.2.6 Nevertheless, the 1997 Business Plan noted that "There is a continuing need to clarify staff roles and professional identity, particularly in several of the newer programs, to achieve optimum team functioning". The Plan also reported that staff at the Centre have been challenged by the changes going on with the WCB. In order to reduce staff anxiety, roles and responsibilities need to be clearly delineated. (p. 27, WP1)

3.2.7 In the current (1998) draft business plan, the continuing need to clarify staff roles and professional identity is mentioned again with particular reference to the newer programs. "The Centre has undergone significant organizational and operation changes in 1997. Many of the staffing roles and levels will be revised in Q3 and Q4 to implement the rollout of the Strategic Initiative Strategy (SIS)." (p.27, 28, 30, WP269)

3.2.8 Successful integration of the workshops into the clinical programs is mentioned in both the 1997 and draft 1998 Business Plans as a CSF for the Centre. (p. 26, WP1, p. 29, WP269)

3.2.9 The 1995 Operational Review commented that "The systems design approach initiated by PERU has further contributed to developing numerous ad hoc system projects; without the appropriate coordination, documentation and effective project management. This provides the Centre's Management with the perception that data base tools such as ACCESS could be utilized to design an integrated clinical information system for use by more than 150 users on the Lan network. Furthermore, the internal Customers interviewed have a perception that PERU have taken on a systems development and technical role for the Centre." (p. 10, WP156)

3.2.10 WCB Practice Directives #12: Claims management and the continuum of care includes a program description with the variations that might be encountered, and adjudicative guidelines. It describes the major Nurse Advisor's role in initiating treatment, as well as when to consult a Medical Advisor on fitness to return to work, and maintaining rtw issues. (p. 1, Ch. 12, WP152)

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

3.3.1 In 1994, the RC reorganized services and created 5 new programs: Work Conditioning, Occupational Rehabilitation, Pain Education, worksite reintegration, and Medical Rehabilitation. They were to operate according to standards set by Commission on Accreditation of Rehabilitation Facilities (CARF). (p. 2, WP118) Additional reorganizations of programs have occurred as evidenced by changes in the PERU reports list.
3.2.2 The 1995 Operational Review commented that "The role of PERU as data base developers requires further clarification and guidance from ISD to ensure compliance with the information systems strategy for WCB. It is not recommended by the Reviewer that PERU or the Centre continues to develop stand alone client server systems, data bases and data collection systems for the Programs. These systems are not integrated or supported by ISD." (p. 13, WP156)

3.3.3 Work Conditioning policy 6.0 indicates that the Work Conditioning Program Steering Committee is responsible for setting policy and standards for work conditioning programs. (pp. 6.0, WP281)

3.4 the necessary delegations of authority and decision-making have been made

3.4.1 The 1996 RCSD Business Plan reported that "Effective February 1, 1995, [the ASTD] customer service initiative was launched in Victoria and Kamloops, Each office received the backlog of ASTD claims belonging to their areas from the queue in ODS which historically had been handled centrally along with the other occupational disease claims for the entire province. By the end of May, both offices had cleared their respective backlogs and now are processing incoming STD claims on a current basis." (p. 4, WP300)

3.4.2 The same plan reported on the objective to improve customer service and consolidate Return to Work activities, and significantly reduce file transfers by the repetitive strain injury file transfer. The status was: successful decentralization to Kamloops, Victoria and Abbotsford SDLs. Comprehensive training package developed. Decentralization to Area Offices to be substantially completed in 1996. (p. 7, WP300)

3.5 these responsibilities etc. are communicated and well-understood

3.5.1 The 1993 Administrative Inventory commented that a lack of timely communication between team members led to inefficiencies in resource utilization. (p. 33, WP252)

3.5.2 From Memoranda of Agreement and Fee Schedules: There is variation in the designation supervision/oversight functions in the memorandums of agreements for MR, OR, WR, and WC regarding the assignment of responsibilities and the description of the nature of the relationships. (WP280)

3.5.3 From Operational Review of the Support Services Area: "While the Central Appointments and Case Records areas have individually documented many policies and very specific business and system procedures, the Support Services area have not consolidated this information into a policy and procedure manual." (p. 8, WP156)
Hypothesis 4: THE DIVISION PROVIDES AN APPROPRIATE WORK ATMOSPHERE

CCAF attribute: 10

Evaluation criterion:

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*

Conclusion

Evidence for this Hypothesis is mixed.

The Rehabilitation Centre has appropriate policies in place to encourage 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 the change processes at the RC have caused considerable upheaval for staff. The evidence seems to indicate that staff have been involved in this change process and that their commitment has made positive change possible.

Research Findings and Evidence

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*

4.1.1 Some findings reported in Hypothesis 10 also relate.

4.1.2 The Centre’s 1993 Annual Report notes that "Maintaining the Centre's quality of service has always been a high priority; the Centre prides itself on having well-trained staff. In 1993, the skills of staff members were recognised in the academic and medical communities. Three Centre staff members received clinical faculty appointments at local universities. The Centre was approved for student placements in physiotherapy by the Universities of British Columbia and Western Ontario. As well, articles on the Functional Evaluation Unit's work were published in professional journals, and a chapter on biofeedback was included in an international reference textbook on pain. Staff members are also in demand as presenters at workshops and symposiums. Management encourages these activities as they help position the Centre as an authority on rehabilitation and aid us in attracting the best qualified staff." (p. 16, WP100)

4.1.3 The Report also noted that "Since clinical skills are critical in rehabilitation, we're encouraging staff to become more involved in developing the Centre's practices. As
well, we're creating more opportunities for staff members to benefit from professional
development courses, workshops, and conferences. The Centre also plans on creating
an atmosphere of teamwork and empowerment by strengthening interdisciplinary
cooperation and respect, and establishing better systems for internal communications."
(p. 17, WP100)

4.1.4 In 1994 staff professional development costs were increased as staff need to keep
current with rehabilitation practice. (p. 5, WP118)

4.1.5 The 1995-2000 Strategic Plan indicates that the Centre's well-trained staff have a
considerable potential for fostering change and innovation. This is seen as a strength.
Weaknesses listed are: staff imbalances in key areas, significant change initiatives
affecting staff morale, and lack of experience or skill in teamwork. Also mentioned is
the image in some areas that the Centre is a dumping ground for very difficult cases. (p.
28, WP158)

4.1.6 The same document identifies threats to the Centre's development, including

- Many staff are experiencing stress related to changes in the Centre's operation
during the past two years. Further changes must be managed well so staff
understand the benefits of change and support the initiatives.
- Continued confusion over role and professional identity may hamper positive
growth.
- Failure to effectively implement the new organizational structure in the Centre may
hamper implementation of our new directions. (p. 29, WP158)

4.1.7 By 1994, the Centre had attended to 47 of 60 attention points identified in the 1993
Administrative Inventory. This could not have been done without an "exceptionally high
level of effort, commitment and service from staff" (p.3, WP118)

4.1.8 Quarterly reports in 1996 noted that in the first quarter, OR was low “due to high staff
turnover, resulting in empty position, inexperienced staff and organizational disarray
have all been systematically addressed" (p. 8, WP14) In the second quarter, efforts were
made to clarify and strengthen the RCAC's role; there was also “improved
communication between staff and senior Centre management”. (p.17, WP14)

4.1.9 By 1996, the status of the objective "to make recommendations for changes to our
current training process to provide quality, cost effective training" was that training
modules were substantially completed. Planning is required for implementation
strategies and resources. (p. 8, WP300)

4.1.10 In correspondence with the commission, the Board notes that research projects
frequently originate from staff concerns and observations. For example, the project on
the multivariate prediction of disability was initiated by the clinical observation that there
is no correlation between impairment and disability. Research on different psychological
tests such as MMPI-2 and the Underlining Test was prompted by the staff-identified need to make these instruments more useful for the injured workers.

4.1.11 In an interview, one of the current co-directors agrees that change is stressful for employees, “despite the fact that they are guaranteed employment under the new contract. They are not necessarily guaranteed a specific job or even the same type of job — and that’s where part of the stress lies.” For example, a year ago there were 25 workshop instructors. Five of these positions were declared surplus. Of the incumbents, some retired; and some were promoted to Prevention Officer or Safety Officer. He noted that “The Centre is different from the rest of the Board. Staff morale is higher in the Centre and always has been. It spiked downward over the last year, probably due to changes and uncertainty. But when I talk to staff I get a good feel.” He also commented that staff, even if they don’t necessarily agree with a change, will live with the change and make it work as happened with the Pain Program. “This is different from the Compensation Services side.” (p. 4, WP442)

4.1.12 With respect to safety, the Centre’s 1994 Annual Report noted that “The Health Unit produced Infection Control Guidelines in an orientation package for staff. An Infection Control Manual is developed and updated on a regular basis.” The unit reviewed the Centre’s health and safety policies in accordance with CARF standards. (p. 15, WP118)
Hypothesis 5: THE DIVISION HAS ESTABLISHED AND IS IMPLEMENTING STRATEGIES TO MEASURE AND REPORT ON THE EXTENT TO WHICH IT IS ACHIEVING ITS OBJECTIVES

CCAFT 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 supported by the evidence.

It is also clear that information and information systems development is an ongoing issue requiring additional resources to meet the criteria to the level that is potentially possible.

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 non-integrated 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 thereby 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 to meet criteria 5.1.
**PERU reports present intended and actual performance. Assumptions and other data qualifiers are included in some reports. The standards in this regard seem to vary. For example, not all reports with the potential for interpretation problems relating to small sample or cell sizes included a warning to the reader.**

One PERU document included an action plan response form. It is assumed that this practice is more widespread. Senior Centre management also report using the data as a key component in focussing attention where it is needed.

Under program evaluation the CARF report states “the Centre is commended for the development and utilization of its clearly presented and relevant program evaluation system. There is evidence the results of the system have been used to improve the operation of the Centre. The results have also been disseminated and used in budgetary and governing body reporting. The members of the program evaluation staff are commended for the timeliness of the reports and for the continuing input from the staff in refining and improving the system. There has recently been a formal review of the system with a commensurate opportunity for reviewing the outcome criteria. The team appears to have relevantly weighted the outcome categories by giving a lower rating to subject pain complaints and emphasizing direct functional parameters in measurement. There is evidence that the program evaluation system is being used in consumer based planning”. (WP117)

CARF considered that both the FEU and BEEP had good ongoing quality assessment when it did its assessment in 1995; they did not, however, comment on the other programs.

**Research Findings and Evidence**

5.1 the Division has identified, monitors and reports regularly and accurately the key items that are crucial for accountability (success/failure)

5.1.1 PERU is the main process used by Centre to identify, monitor and report on programs and their outcomes. It was established in 1992.

5.1.2 An Executive Committee presentation in 1994 outlined program evaluation at the Centre:

"PERU's current responsibilities can be grouped under four headings:
1. continuous program evaluation
2. special purpose program evaluation
3. external program monitoring and
4. other--infrastructure development, consultation, miscellaneous analyses.” (p. 2)

"In setting up a CPE system, we work through a series of steps formally specifying aspects of the program and procedure such as:
• program mission and goals
• program structure
• admission criteria
• needs and characteristics of target group members
• service components
• measurable program objectives
• measures and measurement methodology in relation to objectives
• expectancies for success in achieving objectives
• weightings for objectives." (p. 6)

5.1.3 The 1995 Operational Review (WP156) made several observations and recommendations relating to monitoring and reporting, including:

• the recommendation that “PERU complete an inventory of the current management reports that are produced by the Programs. In addition, PERU should conduct a survey of the priority statistical reports requested by the Programs in order to determine the standard management reports that will be provided as an interim measure. This should take place in conjunction with the senior Management determining the critical success factors and outcome measurement indicators that could be reported to the senior executive at the WCB." (p. 13)

• "Many of the internal Customers commented that the Case Records area have provided "too little decision support information, too late". Consequently, the Customers have requested that PERU provide quick fix data bases for their management information needs. The data bases implemented have been focused on program evaluation and not utilization management." (p. 14)

• "For the most part, the design of RISYS was based on a limited vision for an integrated client information system. The Centre requested to automate the existing manual business processes for the former Work Hardening program. The end users at the Centre were not directly involved in the design process and ISD did not conduct a detailed business process review (BPR) prior to automation. Furthermore, the Centre had requested additional functionality outside of the scope of phase one (ie. scheduling, case record numbering system) which further complicated system design." (p. 9)

• With respect to the Support Services Area: "The type of workload measurement and utilization data that is needed to complete a retrospective productivity analysis was not available in the proper format for the purposes of this review. Statistical reports that were provided either reflected the previous program's organization structure or the reports were difficult to validate when compared with the source data." (p. 2)

• "the Centre should develop a business case and conduct a formal evaluation to purchase an integrated Client/Clinical Information System." (p.15)
5.1.4 The Centre’s 1995 Strategic Plan noted that "There is no capacity to measure what is full utilization of the Centre so that it maximizes its potential and this is being addressed." (p. 5, WP187)

5.1.5 PERU’s report on the Survey of Hand Unit Clients Discharged Between April and June 1995 noted: "a database system is needed that records demographic, program data on all of the HU's clients. This would allow future surveys to test for relationships of program outcome variables, such as attempt to return to work, working at time of survey and satisfaction with HU services. Presently, many program outcome relationships cannot be tested due to lack of data. Planning for an interim solution will begin during the next quarter." (p. i. WP496)

5.1.6 The report for the Second quarter of 1996 noted that the current status of "redesign & implement the referral, admission & discharge process for the Centre" was "redesign of these processes, identification of high level system needs and potential systems solution" The objectives for the third quarter were to implement the new processes for all programs and services, to gain approval to acquire an integrated information system for the Centre to support these processes." The report also stated that in order to improve management information for the Centre, methods were being developed to collect statistics for secondary services of various programs. This is an ongoing initiative. (p.14, 15, WP14)

5.1.7 The Compensation Services 2nd Quarter Report for 1996 notes that "Service strategies have started with hiring of KPMG in early 1996 and selection of the Core and Ad Hoc Design Teams to redesign the Referral, Admission and Discharge (RAD) processes for the Rehab Centre." (p. 4, WP14)

5.1.8 The 1998 Business Plan noted that Referral Admission and Discharge processes had been developed in SIS to provide accurate timely information for management and service delivery. (p. 28, WP269)

5.1.9 Evidence presented in Hypothesis 6 below shows that 20 out of 77 key measures are not tracked. (p. 56, WP305)

5.1.10 In an interview one of the Centre’s Co-directors stated that "While the Centre has moved to a program-based structure, they did not move to a centralized booking/tracking system. Each program developed its own admission system. The solution has been the total reorganization of how people are brought in, tracked, discharged. This required a new computer system. They have been working on this for the last 18 months and are in the final stages of implementation.” (p. 3, WP442)

5.1.11 The Technology Assessment Committee (TAC) was formed in late 1997 in response to numerous concerns as to how the Board reviews new health care technologies, treatments and assessment tools. This committee is multi-disciplinary and comprises
individuals from both Medical Services and the Centre, and two members from the British Columbia Office of Technology Assessment. The committee’s mandate is to systematically and comprehensively review the literature on selected topics and provide recommendations to the Executive Director of Rehabilitation Services as to what the literature may or may not reveal on a particular topic. As well, the group is to prioritize all requests that come before it. It is expected that the group’s first topic will be completed by May 1998.

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

5.2.1 At the SEC presentation November 1994, it was reported that the BEEP now has timely, thorough, independent, objective information on whether they are achieving their program goal of safe effective return to work. For PERU to provide this type of information requires one third of an FTE for data entry, one quarter of an FTE of a program evaluator, and time for program staff to respond. (p. 1)

5.2.2 While PERU may be able to collect program data in a timely and apparently cost effective way, “one of the challenges facing the division in 1997 is the weakness of the Information Systems function, particularly with respect to management information and decision support”. (p. 15, WP1) This may be more critical for other parts of RCSD, because PERU is able to address many information needs; nevertheless it does affect the Centre which is said to require "significant" support from Information Services in order to achieve its 1997 objectives. (WP4)

5.2.3 As noted in Hypothesis 2 above, "A blueprint of business requirements is being developed that will map out the strategies and initiatives in terms of hardware/software/application/data implications as well as human resource requirements to support the infrastructure." (p.14, WP1) This may be an indication that a strategic information plan exists for the Division. However, it is not explicitly stated.

5.2.4 One of the co-directors, in an interview, stated that at end of this year, they plan to move away from having a high level of staff involvement in data collection, to a seamless system, fully automated/computerized, that will give changes daily. It will include both internal and external programs, and will include every program in the province that serves Rehabilitation Centre clients. (p. 3, WP441)

5.3 the indicators used actually measure performance and organizational strength (i.e. they are meaningful)

5.3.1 The 1995 Business Plan lists (p.34, WP4) indicators in support of Priority 1 for RS that RS activities will be outcome oriented. The indicators are presented as topics rather than specific measures. For example: timeliness of referral is used rather than, say, percentage of referrals received and acted upon within 10 days of contact. Without
further analysis, we cannot conclude whether ‘timeliness’ and the other indicators presented in the Plan do in fact serve as actual measures.

5.3.2 Evaluation Procedures are formalized according to CARF standards. PERU provides data needed to formally evaluate programs. (p. 2, WP118)

5.3.3 Cominco, in their submission to the commission, reported their frequency of lost time incidents has dropped over the last four years, as have the severity rates. The 'attached' graph was not included in the copy for the researchers. It appears severity ratings are problematic for the WCB and better definitions are needed and problematic for WCB.

5.4 performance information is provided on a timely basis so that results can be used in other management processes (planning, budgeting)

5.4.1 The 1995 Operational Review reported that "While the Case Records area have manually coded, counted and abstracted data into the PRISM system, the report writer and the information have not been well utilized by the internal Customers, PERU and the Centre's Management. This may be attributed to the coding and abstracting area having a 2-4 month backlog." (p. 12, WP156)

5.4.2 The second quarterly report, 1996 noted that to establish and manage utilization targets for all programs and services, utilization results are now tracked weekly. (p. 4, WP14)

5.4.3 The 1997 Business plan reports that timely, accurate management information is anticipated as a result of the implementation of recommendations from the Referral, Admission and Discharge Processes. (p.25, WP1)

5.4.4 In the External Interdisciplinary Pain Programs Customer Satisfaction paper, "Only 13% of customers [primarily claims adjudicators, with a few vocational rehabilitation consultants] felt that they had not received the discharge report within an acceptable time frame." (p. 1, WP454)

5.4.5 The First Quarter 1997 Program Evaluation Report on the Functional Evaluation Unit notes: "As in previous quarters, this quarter's report turn around of 24 days once again exceeds its goal of 7 days for this objective. Again, FEU should reconsider whether a 7 day turnaround time is a realistic expectancy for this objective in the near future." (p. ii, WP471)

5.4.6 In an interview, one of the co-directors noted that "Until recently, figures were reported quarterly; now key performance indicators are pulled out as stand-alone figures and reported monthly. Previously, these figures were incorporated in lengthy narrative reports. Now they jump out at the reader, due the change in presentation, and the information is much more current. So the management team is much more able to use it — it is more user-friendly." (p. 1, WP442)
measured outcomes and impacts/findings are used to ensure increasingly limited resources are used in a more/the most relevant, economic and effective manner

Complaints about waitlists for admissions being too long and that cancellations resulted in 5% resource waste were raised in the 1993 Administrative Inventory. (p.29, WP252).

A report was made to Executive Committee in May 1994 on the evaluation of the Early Intervention Project. "When direct comparisons were made between the full experimental and control groups, they failed to show any substantive difference between these two groups either in time to wage loss being finalised or in total costs to the Board. As the sample size is very large (518 individuals), it is clear that the early intervention project, despite high client satisfaction ratings, failed to change the behaviour of injured workers in the experimental group." (p.1) Mr. Feehan recommended that the program continue to year end with no possibility of extension as a pilot to allow for analysis of subgroups, and predictors for targeting at risk individuals, as well as trying different combinations of audience and session presentations. As the largest expense was in program set up, this would allow the program to demonstrate its ongoing utility at minimal costs, providing the data to decide whether to make the program a permanent one or to stop it entirely. (p. 2)

By 1995 the Centre will have completed a full cost recovery program. This will enable management to better track resources and to ensure that the rehabilitation services provided are cost effective. (p.5, WP118)

"The actual discharges in the Functional Evaluation Program is significantly lower than budget due to the low number of referrals. This has resulted in an initiative to get feedback from the VRC's regarding the reports provided to them. Functional Evaluation Program is looking at a strategy to minimize preventable last minute cancellations and where they occur, a mechanism to fill on shorter notice. The discharges and occupancy statistics only look at 2-week evaluations; the Functional Evaluation Program is also involved in shorter evaluations and other assessments which are not included in the above numbers. Discussions have begun with PERU to reconsider the statistics being collected for the Functional Evaluation Program". Second quarter of 1996. (p. 9, WP14)

The Work Conditioning Provider Payment System includes incentive payments based on: Working at 3 Month Followup, Discharged as Fit to Return to Work Without Limitations (FIT), Length of Stay, and Client Satisfaction. (p. 1, WP281)

From the Worksite Reintegration Program, Clients Discharged in Quarter Two 1996: "As this is a first review of the program's discharge data, recommendations include that the length of stay and discharge status objectives be monitored. In addition, the ratio of WRP clients to non-WRP clients who receive program services should be examined." (p. 1, WP463)
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

5.6.1 Through its PERU reports, the Centre probably meets this criterion better than any other department with the WCB.

5.7 reports present data/information and analysis that is accurate, reliable, consistent, complete, meaningful, timely, replicable, impartial and that states assumptions used

5.7.1 While PERU reports are generally of high quality, some problems were found. We cite examples of problems in three areas: consistency of data, sample/cell size, and methodology.

5.7.2 Consistency of data, including problems with definitions:

- RISYS does not count as an occupancy, the day of admission or the day of discharge thereby distorting the actual number of days of treatment.” (p. 8, WP14)

- "The statistics produced from the reports on the RISYS system and the PRISM system often cannot be validated. This has been attributed to incorrect discharge data being recorded and amended in RISYS and the incomplete processing of the case records in a timely manner.” (p. 12, WP156)

- From External Work Conditioning Program Summary 1996: "There are some inconsistencies across clinics regarding the discharge status as not all appear to be using the same criteria. For example, when a recommendation is made for the client to participate in a GRTW, most clinics discharge the client as fit to return to work with limitations. A few clinics, however, select the without limitations category. A new policy has been created which clearly delineates the criteria appropriate for each discharge status category that the clinics should adhere to. This policy has been given to all clinics participating in the WCP.” (p. 2, WP491)

5.7.3 Sample and cell size:

- From External Work Conditioning Program Summary 1996: "It should be noted that for some clinics the number of clients discharged were small so percentage results should be interpreted with caution. Where the number is smaller than five, percentage values are not calculated." (p. 2, WP491)

- From the Summit Follow-Up Report, 1994: "Given the small size of the sample in this study, it is difficult to draw conclusions about the Program. The findings do, however, provide some interesting preliminary information on the program." (p. 11, WP492)
5.7.4 Methodology:

- Hand Unit Followup: A Mail and Telephone Survey of Discharged Hand Unit Clients. February 15, 1995. "A branching/interpretation problem concerning the mailed questionnaire surfaced in this survey. In spite of a filter question, more workers (84) reported working in the week prior to the survey than the number (82) who said they had worked at all for pay since discharge." (p. i, WP495)

5.7.5 In an interview, the Vice President, RCSD noted that he gets annual duration figures one month after the year closes out; this is often too late and there is often no information to support why certain results occurred. Neither he nor his staff can react to situations in a timely way. Delayed reporting makes it difficult to communicate to both staff and the outside community. (p. 1, WP498)

5.7.6 With respect to the budget process, one of the co-directors in an interview noted that he is “comfortable with the level, accuracy and timeliness of information." (p. 2, WP441)

5.8 reporting is subject to verification/audit

5.8.1 The PCs and LANs in the Centre were subject to internal audit in 1995 to determine if they were being used for high risk, critical functions. The audit was also to ensure that the PCs and LANs were secured from unauthorized access and that there were procedures to minimize operational disruptions. More than half of the Centre's PCs represented a medium to high risk if used improperly. There was a high risk of unauthorized and untraceable accessed to the LAN, as well as issues with regard to passwords. Management response to the report was agreement with the factual content and commitment to a variety of actions by both Centre and ISD staff to correct the situation. (WP175)

5.9 performance information is the basis on which decisions are made

5.9.1 PERU uses research methods to provide evaluation data for the RC. The results are used to assess client and customer needs and determine future directions for the Centre. (p. 18, WP118)

5.9.2 One of the quarterly PERU reports had attached to it an action plan response form. This form was filled out in response to a particular program evaluation report. It included action plans (finding, target dates, persons responsible, and utilization categories) as well as actions where planned or in progress (findings, target dates, persons responsible, and utilization categories).

5.9.3 During a site visit, the research team were shown a wall chart in the Rehabilitation Centre on which results for the last three months are posted by program. All staff can see the chart. This tracking allows both management and staff to identify where likely
problems are and where the focus needs to be; it also assists with the analysis of
problems and causes. Having the numbers updated regularly and in an open place has
brought a lot of focus to them and increased staff ownership. Staff are very proud of
their successes. “With regular tracking and posting, and with the clear focus on rtw
internally, there has been a huge improvement in rtw outcomes.” (p. 2, WP441)

5.9.4 While the co-directors agree that there could always be more and better data, they
believe that data are being well used in the Centre; they have taken a big step towards
using the data they have. (p. 1, WP442)
Hypothesis 6: THE DIVISION IS ACHIEVING ITS OBJECTIVES

CCAF attributes: 1 (in part), 3, 4, 5

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

There is good evidence to support this hypothesis.

PERU provides an enormous weight of evidence regarding programs’ achievement of their objectives. Due to time constraints, the researchers could only review a sampling of these reports (approximately 60). In general, it would appear that the Centre’s programs are achieving their objectives. A program might fail in a specific quarter of a year to meet one or many of its objectives. However, since the researchers could not review every quarter for all the 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.

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 Centre has responded to research evidence, community consultations and other environmental trends to keep its programming relevant. Examples are the use of multidisciplinary teams to treat chronic pain clients, delivering rehabilitation services "closer to home" through the Board certification of 65 private physiotherapy clinics to provide work conditioning programs”, 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.

Even with the wealth of evidence produced by PERU, key indicators are not tracked for all programs and additional data development is required to respond conclusively to this hypothesis.

CARF requires organizations to adhere to the following principles:
• Promote the basic human rights, dignity, health, and safety of the persons served.
• Demonstrate that the persons served are involved in the individual planning, decision-making, and implementing of the services they will receive.
• Provide services that are designed to enhance the independence, self-sufficiency, and productivity of the persons served.
• Provide coordinated, individualized, goal-oriented services leading to desired outcomes." (p. 42, WP100)

In March 1995, the Lesley Peterson Rehabilitation Centre was accredited for a period of three years for the following programs: Chronic Pain Management Programs, Outpatient Vocational and Employment Services, Vocational Evaluation.

Research Findings and Evidence

6.1 the Division is achieving what is set out to do

6.1.1 The 1996 Administrative Inventory reported that "The comprehensive Rehabilitation Centre in Richmond is one of the jewels in the WCB crown. The Functional Evaluation Unit is unsurpassed in its technical sophistication. The broad array of rehabilitation benefits is outstanding. Rehabilitation performance figures seem only average however." (p.256, WP18)

6.1.2 We have reviewed a wide range of documents that record outcomes. Samples of our findings are presented below under the headings use, targets/objectives achievement, return to work, and external providers. Comments may relate to more than one heading; they are recorded where they seem most appropriate. They are also presented in ascending date order.

6.1.3 Use:

• 1994: The Centre’s 1994 Annual Report noted that reduced waiting lists for the FEU were achieved through increasing triage activity to screen out inappropriate referrals, educating referral sources as to what an appropriate referral is, and aggressively rebooking cancellations. (p. 9, WP118)

• Second quarter 1996: "there continues to be too many no-shows in MR and OR where the client was unaware of his/her appointment. Management is working with Support Services to rectify this problem." (p. 8, WP14)

• Quarter four, 1996: Program Evaluation Report on the Occupational Rehabilitation Program: Utilization remained low during quarter four. ORP needs to capitalize on increasing the number of referrals to the program and decreasing the length of stay in order to improve its overall utilization.(p. 6, WP469)
6.1.4 Targets/overall objectives achievement:

- 1994: the Amputee Program completed a client outreach to seniors re: safety facilities at home, prosthetic support, and day to day management. Follow-up for seniors with needs was initiated. (p.12, WP118)

- 1995 Hand Unit Annual Report: Outcomes of Hand Unit Clients Discharged in 1995. "The Hand Unit met every one of its program objectives that it was collecting data for in 1995". (p. 16, WP476)

- Quarter two 1996 Worksite Reintegration Program: "The program met its target for the referral to admission objective as 80% of these clients were admitted within 10 days of referral. The program did not meet its target for the client length of stay objective as only 43% of clients were discharged within six weeks." (p. 1, WP463)

- Quarter four 1996 Program Evaluation Report on the Medical Rehabilitation Program: Program effectiveness was not as successful regarding improvements gained during treatment. None of the targets were met for the 4 areas for which data was available.

- Quarter four 1996, Program Evaluation Report on the Medical Rehabilitation Program efficiency can be improved as Medical Rehabilitation met 1 of 4 targets. Timely completion of discharge reports is the program's strength. The wait for the program also improved, even though it did not meet the target. Utilization and length of stay also did not meet their targets." (p. ii, WP466) [The research team note an apparent inconsistency between this and the paragraph above in terms of whether targets were met.]

- First quarter 1997, Program Evaluation Report on the Functional Evaluation Unit: "In terms of efficiency, the FEU surpassed its goal in maximizing program efficiency, and continues to significantly surpass its goal in minimizing wait for program admission." (p. ii, WP471)

6.1.5 Return To Work

- 1994 Rehabilitation Centre Annual Report: When surveyed, 67% of clients from the Hand Program surveyed three months after discharge said that they had worked in the previous week. (p.8, WP118)

- Follow-Up of 1994 Head Injury Clients: "30% (6) reported having attempted to return to work after their head injury assessment. None of these clients reported to returning to regular duties. Sixty-seven percent (4) of these clients said they
had different job duties compared to what they had had before their head injury." (p. 1, WP480)

- 1995 Quarter four follow up: Program Evaluation Report on the Work Conditioning Program: "Eighty-four percent (32/38) of fourth quarter WCP clients contacted during a PERU follow-up survey were working three months post-discharge. This surpasses for the first time the program's target of 80% and exceeded the rate attained in the third quarter by 13%." (p. 1, WP462)

- Quarter four 1996, Program Evaluation Report on the Occupational Rehabilitation Program: “The percent of clients working 3 months post discharge continued to increase for the second subsequent quarter. The overall outcome, however, remains below the target established by the program. Ongoing modifications to ORP, including treating a population which is earlier in its time since injury, will likely assist the program in improving the return to work outcome. Another key area to concentrate on is job attachment, as clients with a job to return to upon discharge are more likely to be working 3 [months] after their discharge.” “The percent of clients no longer receiving WCB payments increased for the third subsequent quarter and was better than the target established for this area.” (p. 6, WP469)

- Quarter four 1996, Program Evaluation Report on the Medical Rehabilitation Program: The Medical Rehabilitation Program met critical long term effectiveness goals, as seen in the return to work rate and the percent of clients no longer requiring compensation. In comparison, the goal of assisting clients to achieve long term independence from the medical system was not met.

- Quarter 1 1997, Program Performance Report, Interdisciplinary Pain Program Network: "Return to Work Outcome: RTW at discharge 53%, RTW at 3 months 44% (21/48), same job/employer at 3 months 48%, worked since discharge 49%." (p. 1, WP483)
6.1.6 The following table shows three different outcomes for a variety of programs.

<table>
<thead>
<tr>
<th>Program</th>
<th>Injury to Admission (days)</th>
<th>Fit to RTW at Discharge (%)</th>
<th>Durable RTW % (3 mos post discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td>Work Cond</td>
<td>83</td>
<td>66</td>
<td>54</td>
</tr>
<tr>
<td>Occ'l Rehab</td>
<td>222</td>
<td>252</td>
<td>246</td>
</tr>
<tr>
<td>IPP</td>
<td>338</td>
<td>305</td>
<td>306</td>
</tr>
<tr>
<td>Med Rehab</td>
<td>246</td>
<td>261</td>
<td>268</td>
</tr>
<tr>
<td>Hand</td>
<td>63</td>
<td>45</td>
<td>48</td>
</tr>
<tr>
<td>Head Injury</td>
<td>518</td>
<td>438</td>
<td>401</td>
</tr>
<tr>
<td>Amps</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Wksite Reint</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Fun N/A Eval</td>
<td>1,095</td>
<td>1,022</td>
<td>767</td>
</tr>
</tbody>
</table>

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

"Fit to Return to work at discharge measures the percentage of clients able to return to work at end of treatment. This contrasts with the Durable Return to Work indicator which measures the percentage of clients, who, 3 months after discharge, are still working. The ongoing focus in the Rehabilitative Centre is to increase Durable Return to Work as it results in increased cost savings for the Board in the long run." (p. 5, WP305)

6.1.7 In correspondence with the commission, the Board noted that incoming referrals are reported as discharges in the Business Plan as all clients receive a discharge status: of assessment only, completed program, or did not complete program. The Board also provided the following statistics on referrals to the Rehabilitation Centre only: this table thus represents the Centre’s workload.
<table>
<thead>
<tr>
<th>Year</th>
<th>Incoming Referrals</th>
<th>Occupancy (days of treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>1995</td>
<td>2,516</td>
<td>56,054</td>
</tr>
<tr>
<td>1996</td>
<td>2,600</td>
<td>57,972</td>
</tr>
<tr>
<td>1997</td>
<td>2,908</td>
<td>61,017</td>
</tr>
</tbody>
</table>

6.1.8 In correspondence, the Board provided the following information regarding the average and median length in days between injury and date of admission to the Rehabilitation Centre.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>WCP int</td>
<td>96</td>
<td>81</td>
<td>91</td>
<td>75</td>
<td>72</td>
<td>64</td>
<td>76</td>
<td>60</td>
</tr>
<tr>
<td>WCP ext</td>
<td>186</td>
<td>104</td>
<td>204</td>
<td>98</td>
<td>145</td>
<td>77</td>
<td>88.2</td>
<td>50</td>
</tr>
<tr>
<td>FEU</td>
<td>n/a</td>
<td>n/a</td>
<td>1,646</td>
<td>956</td>
<td>1,775</td>
<td>1,043</td>
<td>1,520</td>
<td>917</td>
</tr>
<tr>
<td>HANDS</td>
<td>150</td>
<td>56</td>
<td>135</td>
<td>61</td>
<td>78</td>
<td>54</td>
<td>80</td>
<td>58</td>
</tr>
<tr>
<td>HEAD</td>
<td>n/a</td>
<td>n/a</td>
<td>1,224</td>
<td>718</td>
<td>854</td>
<td>480</td>
<td>933</td>
<td>602</td>
</tr>
<tr>
<td>ASTD int(^1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>249</td>
<td>283</td>
</tr>
<tr>
<td>IPP int</td>
<td>n/a</td>
<td>n/a</td>
<td>503</td>
<td>369</td>
<td>387</td>
<td>323</td>
<td>366</td>
<td>223</td>
</tr>
<tr>
<td>IPP ext</td>
<td>n/a</td>
<td>n/a</td>
<td>321</td>
<td>521</td>
<td>488</td>
<td>314</td>
<td>563</td>
<td>311</td>
</tr>
<tr>
<td>OR int</td>
<td>511</td>
<td>271</td>
<td>388</td>
<td>250</td>
<td>445</td>
<td>223</td>
<td>304</td>
<td>174</td>
</tr>
<tr>
<td>OR ext</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>263</td>
<td>134</td>
</tr>
<tr>
<td>MR</td>
<td>390</td>
<td>212</td>
<td>464</td>
<td>249</td>
<td>618</td>
<td>251</td>
<td>585</td>
<td>213</td>
</tr>
</tbody>
</table>

\(^1\) program not in existence until 1997; tracked from Oct-Dec 1997

6.1.9 In correspondence with the commission, the Board provided the following statistics on return to work at discharge and still working at 3 months after discharge.
<table>
<thead>
<tr>
<th>Program</th>
<th>1994 RTW @ discharge 3 mths</th>
<th>1995 RTW @ discharge 3 mths</th>
<th>1996 RTW @ discharge 3 mths</th>
<th>1997 RTW @ discharge 3 mths</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCP internal</td>
<td>55%</td>
<td>85%</td>
<td>89%</td>
<td>81%</td>
</tr>
<tr>
<td>WCP external¹</td>
<td>42%</td>
<td>54%</td>
<td>70%</td>
<td>80%</td>
</tr>
<tr>
<td>FEU</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>HANDS</td>
<td>n/a</td>
<td>62%</td>
<td>61%</td>
<td>52%</td>
</tr>
<tr>
<td>HEAD</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>ASTD internal²</td>
<td></td>
<td>62%</td>
<td>n/t</td>
<td></td>
</tr>
<tr>
<td>IPP internal</td>
<td>n/a</td>
<td>42%</td>
<td>64%</td>
<td>69%</td>
</tr>
<tr>
<td>IPP external</td>
<td>n/a</td>
<td>40%³</td>
<td>60%</td>
<td>49%</td>
</tr>
<tr>
<td>OR internal</td>
<td>n/a</td>
<td>17%</td>
<td>26%</td>
<td>43%</td>
</tr>
<tr>
<td>OR external</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>37%</td>
</tr>
<tr>
<td>MR</td>
<td>n/t</td>
<td>n/t</td>
<td>13%</td>
<td>12%</td>
</tr>
</tbody>
</table>

1 durations tracked for WCP external RTW @ 3 months for selected months only
2 program not in existence until 1997
3 IPP ext 1994 RTW @ 3 months tracked Jan-Nov only
4 OR ext 1997 RTW @ 3 months tracked fourth quarter only

In the above table, for 1997 RTW @ 3 months is based on a ‘liberal RTW’ basis i.e. it includes clients who said they were not working at 3 months follow up but who attributed this to reasons not related to their claim injury. Otherwise, all outcomes for RTW @ 3 months, previous to 1997, are based on ‘working’ status.

6.1.7 External delivery:

- 1994: "A third-party physiotherapy pilot program, launched in late 1993 to provide injured workers with faster, more effective rehabilitation services in their own communities, continued throughout the year [1994]. While the treatment success rate has been consistent with similar programs in other jurisdictions, WCB targets have not yet been achieved, largely due to a higher than desirable lag between injury and program admission. Results of this pilot underscore the need for early intervention to prevent injuries from becoming chronic. In response, early intervention tracking software is being developed that will alert adjudicators to
cases that appear at risk for prolonged disability. And as part of the wider integration of their functions, clinical and claims staff will work together to determine the best early intervention practices." (p. 22, WP350)

- **External Interdisciplinary Pain Programs 1995 Annual Report.** "Overall, none of the targets set for program objectives were met in 1995." "The return to work rate overall was low but improved over most of the year." "Although all of the external pain programs meet minimum standards, the overall outcomes varied widely." (p. 1, WP455)

### 6.1.8
The Vice President RCSD in his 1997 presentation to the commission noted: "Without intervention the Soft Tissue Continuum looks something like this. We have 40,000 workers a year who suffer soft tissue injuries in the workplace, and without any kind of clinical intervention at the end of 24 weeks there would be 4,400 people continuing to be on claim without returning to work, for whatever reason.

Our Early Intervention Strategy which is now up and running across the province requires that our staff — and we have dedicated, trained staff who do this job full time — ... workers are telephoned at three weeks post-injury. They are asked if they're working or expecting to return to work within the next week. If they are not, they are encouraged to see their physicians and discuss the opportunity for a treatment program.

We contact the physician and we discuss whether the worker is appropriate for a work conditioning program, and the adjudicator is advised of what the outcome of that interaction is.

The impact of early work conditioning is that we get a 75 to 85 per cent return to work outcome to worker's pre-injury employment, and what we're doing here is really shrinking the passive modalities associated with physiotherapy to three weeks, and moving to active modalities in the work conditioning program at the three to four week point, whereas historically workers would have received eight, ten, twelve weeks of passive physio almost as a matter of routine." (p. 72-73, WP25)

### 6.2
**the programs/services the Division delivers are relevant**

#### 6.2.1
The Rehabilitation Centre’s 1994 Annual Report noted that the FEU and Occupational Diseases Claims Unit cooperated on an early intervention project for Repetitive Strain Injuries (RSI). The results found that all clients in the treatment group considered the intervention services positive and productive. (p. 23, WP118) The number, however, was relatively small.

#### 6.2.2
The Board’s 1994 Annual Report indicated that the "coordination of rehabilitative services closer to workers' homes resulted in a 10 percent reduction in volume over last year, while treatment days at the Centre remained constant as a result of its focus on more complex cases." (p. 21, WP350)
6.2.3 The CMA’s policy summary, ‘The physician’s role in helping patients return to work after an illness or injury’ states: "Successful return to work involves primarily the employee and his or her employer and requires the assistance of the attending physician. When appropriate, patient care and outcomes may be improved through a coordinated multidisciplinary approach involving other health care professionals, including other physicians, rehabilitation specialists, nurses, physiotherapists, occupational therapists, psychologists, case managers, vocational specialists and personnel of employee assistance programs. When available, occupational health and safety services, which may involve physicians and other expert personnel, can be an invaluable resource for the attending physician and patient." (p. 2, WP43) This supports the interdisciplinary approach utilized at the WCB.

6.3 The constituencies to which the programs/services are directed judge them to be satisfactory

6.3.1 There are many statements regarding satisfaction. A sample of these is presented below in ascending date order.

• 1993 Annual Report: "Managing to meet CARF standards has already had an impact on the Centre's operations. In the area of client satisfaction, we conducted nine program evaluation surveys that have led to:
  • Increased direct client input programs
  • Increased reporting and liaison with referral sources
  • Increased development of linkages with worksite employers." (p. 14-15)

• Stakeholders representing the broadest spectrum of interests generally value the Centre positively. Hence, it is an asset to the Board, both in its specific service provision, but also more generally as a positive demonstration of the Board's mandate in action." (From a presentation to SEC by Dr. Jessup, p. 4, WP497)

• 1994: Overall Client Satisfaction with Head Injury Assessment Clients. "Very satisfied or satisfied 45% (9)." (p. 2, WP480)

• 1994: 83% of clients surveyed in the last three quarters of 1994 indicated that they were satisfied or very satisfied with the services they received. (p.7, WP118)

• 1994: The Amputee program received a 93% client satisfaction rating. (p.12, WP118)

• "Although survey results differed among the respondent groups, the responses confirmed that the Centre’s emphasis on return to work services and introduction of the Pain Education Program answered clients’ needs." (p.19, WP118)
• 1994: The FEU and Occupational Diseases Claims Unit cooperated on an early intervention project for Repetitive Strain Injuries (RSI). The results found that all clients in the treatment group considered the intervention services positive and productive. (p.23, WP118)

• 1995 Hand Unit Annual Report: Outcomes of Hand Unit Clients Discharged in 1995. "more than half of clients in 1995 said that the Hand Unit met their expectations (69%). A little over half of clients in 1995 said they felt they were ready to leave the Hand Unit and agreed with their discharge recommendations at discharge (53% and 57% respectively)." (p. 17, WP476)

• 1996: The second quarter report for 1996 notes under the heading "Continue to focus on meeting client needs and expectations" that progress has been made on developing the Residence Review action plan to address Safety and security issues, with plans for implementing the changes by November 96. This appears to be in response to client feedback. (p.15, WP14)

• Quarter four 1996, Program Evaluation Report on the Medical Rehabilitation Program: Clients of Medical Rehabilitation report very high satisfaction with the program with 88% either satisfied or very satisfied with the services received. (p. ii, WP466)

• 1996: "Local customer surveys slated for 1996 will ensure that activities are focused on the most significant customer service issues." (p. 51, WP300)

• Second quarter 1996: Customer and client focus groups were used to gather input for the Service Improvement Strategy and the Residence Review in the second quarter of '96. Plans for the third quarter are to implement the changes being developed in that project by year-end. (p. 15, WP14)

• First Quarter 1997, Program Evaluation Report on the Functional Evaluation Unit: “91% of clients indicated they were satisfied or very satisfied with FEU’s services for this quarter. This outcome exceeds the goal of 85% for this program, objective." (p. ii, WP471)

6.3.2 The following relate to satisfaction with external providers.

• External Multidisciplinary Pain Programs 1994 Client Survey, "Overall satisfaction with the services received was quite high with 44% (39/88) and 25% (22/88) of clients stating they were satisfied or very satisfied respectively." (p. 7, WP453)

• 1995, External Interdisciplinary Pain Programs Customer Satisfaction Evaluation: "Just over half (53%) of customers [primarily claims adjudicators; a few vocational rehabilitation consultants] were satisfied with the results the client
achieved in the program." "Overall, 66% of [these] customers were satisfied/very satisfied with the services they had received from the program." (p. 1, WP454)

- Quarter three 1996 Discharges. External Work Conditioning Programs, Client Follow-Up: "74% of survey respondents indicated they were either satisfied or very satisfied with the services they received while in the Work Conditioning Program." (p. 1, WP464)

6.4 the Division is able to identify secondary impacts and eliminate those that are negative, and build upon those that are positive

6.4.1 An example of a secondary impact identified through the Centre’s research was presented in the Compensation Services Performance Report for the Second quarter 1996: "Hand Program: referrals from external sources were lower than expected. Possible reasons include: surgery and therapy may be happening more frequently in local communities, and/or there were less serious traumatic hand injuries because of increased safety in industry, or fewer people working in industries such as forestry and fishing." (p. 8-9, WP14)

6.4.2 To assist it find out about secondary or unintended impacts in the area of service quality, the Centre reported in 1993 that it had begun:

- Team-building training in the Work Hardening Program with follow through to integrate professional treatments and reports
- Establishing quality assessment mechanisms
- Conducting case treatment and file audits. (p. 14-15, WP100)
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)

Conclusion

While there is some data for both criteria, it is not possible to determine whether the Hypothesis is met and whether the Rehabilitation Centre is achieving its objectives in a cost-effective way.

The Rehabilitation Centre is constrained somewhat in its ability to identify and analyze input/output relationships by the organizational legacy of "siloed" or independent information systems. However, Centre management indicates that good information is available on costs. Some conclusions have been made about the cost-competitiveness or cost effectiveness of specific programs. Management staff outside of the Centre have indicated that gaps exist. The lack of depth in the evidence for this hypothesis suggests further developmental work is still required.

The CARF report did not refer specifically to cost-effectiveness.

Research Findings and Evidence

7.1 the Division is able to identify costs, inputs and outputs and determine the relationship between them

7.1.1 In a presentation by Dr. Jessup on cost containment in rehabilitation (undated), he asked "Are multidisciplinary pain clinics effective? 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. e.g. 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 compared 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." (p. 5-6, WP157)

7.1.2 In the 1995 Compensation Services Business Plan, the Rehabilitation Priority was that the quality and outcomes of rehabilitation would meet or exceed international standards for professional rehabilitation and cost effectiveness. Strategy 1 under this priority was that all rehabilitation activities would become outcome-oriented. Actions would include regular external bench-marking, conducting post-discharge and in-treatment surveys, and undertaking cost/benefit analyses of selected rehabilitation services. Strategy 2 was achieving accreditation first for FEU, BEEP and the Hand Unit, and then moving on to other programs. Strategy 3 was forming partnerships for effective treatment closer to home. The final strategy was the development of better treatments and outcomes through research. (p.34-37, WP4)

7.1.3 The Centre’s 1994 Annual Report stated that by 1995 the Centre will have completed a full cost recovery program. This will enable management to track resources better and to ensure that the rehabilitation services provided are cost effective. ( p. 5, WP118)

7.1.4 The Association of Workers’ Compensation Boards of Canada’s *Compensating for Chronic Pain* (1997) notes that chronic pain “was addressed by a task force in British Columbia, which estimated that the Workers’ Compensation Board of British Columbia, was dealing with at least 1,000 chronic pain cases at the six month interval, at a cost of at least $140,000 each.” (p. 1, WP123)

7.1.5 In an interview, one of the co-directors for the Centre noted that the Centre has always had good info on costing e.g. salaries, physicians, cost of specific programs, and could identify what costs would be incurred by change. They know the full cost of the Centre, including depreciation of the buildings, utilities, all staffing costs. For individual programs, these overheads are broken down by either the percentage of the facilities used by a program (floor space) or by an even division e.g. PERU. Thus, managers
know the full costs of their programs. Generally, indirect costs (facilities, depreciation, central administration, PERU, central records) comprise 50% of costs, and direct costs (staffing, mailing, telephone, transportation, education, conferences etc.) comprise the remaining 50%. (p.1, WP441)

7.1.6 The following references comment on the cost-effectiveness of specific programs:

- The Centre’s 1994 Annual Report noted that Clients who participated in the 1994 RSI early intervention strategy did not reopen claims at six months after injury. These results are promising and could lead to considerable cost savings for the Board. (p.23, WP118)

- 1996: The Amputee Unit was consolidated with the Medical Rehabilitation Program as the Amputee unit was no longer cost effective as a single program. (p.3, WP14)

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)

7.2.1 The 1993 Administrative Inventory reported that lack of communication has led to inefficiencies in resource utilization. It also noted that the BEEP is "felt to be cost effective". Staff estimates are included that indicate for the 2,678 workers who could participate in a program like this WCB could save a third of a million dollars collectively. (p.33, 61, WP252)

7.2.2 In an interview, the RCSD Division Controller and the Finance and Administration Manager noted that “Determining cost effectiveness is not done on a day to day basis, except for productivity within a business unit”. The Board and the Division are still a long way from activity-based costing.

7.2.3 Nevertheless, the Centre reports that it has made some attempts to conduct cost effectiveness analyses. A sample of these statements includes:

- 1993 Rehabilitation Centre Annual Report: "To measure cost-effectiveness, the Centre implemented some major reviews. The Controller's Department undertook an accounting review to determine the actual cost of each unit of service delivered in each program. We also began reviewing what happens to clients after discharge. In addition, we will be establishing:
  • A Utilization Committee to ensure efficient operations.
  • An improved management information system to measure and enhance effective use of the Centre's treatment capacity. (pp. 14-15).

- 1994 WCB Annual Report: "Committed to continually improving the quality and cost-effectiveness of the rehabilitation services it delivers, the WCB engaged in
innovative research in 1994. The Centre conducted a pilot project in the treatment of back pain, a persistent, widespread source of WCB claims, and another in the area of repetitive strain injuries, a growing claims source.” (p. 1, WP350)

- 1994 SEC Minutes: "The FEU and BEEP projects are cost-competitive with outside agencies. The Work Hardening program has not been competitive to date due to volumes. Better utilization would increase competitiveness. The Residence is competitive. The Hand Clinic and Amputee Unit are more costly, but due to volume of cases, there is a great deal of expertise required and this translates to higher costs.” (p. 3, WP188)

7.2.4 In an interview, the Vice President RCSD noted that he is “convinced that board could outsource most of the services it offers for lower cost than they can deliver internally”. He plans to do some initiative/activity based costing to ensure that when staff do cost effectiveness analysis they are comparing like with like. He feels staff to date have not appropriately captured the cost of items such as facilities, governance, overheads, length of work week, time off, staff benefits package. (p. 5, WP498)
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

Conclusion

The Hypothesis is partially supported by the evidence available to the team.

The Rehabilitation Centre is in a good position to maintain or improve results because of its program evaluation capacity. Much of the evidence connected with PERU has been presented earlier in this report under Hypotheses 5 and 6. PERU has ensured the Centre’s staff and management have results data regarding maintaining and improving results.

There is no evidence reviewed by the researchers that indicates analyses for future capacity requirements have been done, although, Dr. Jessup (previously the Centre’s Executive Director) made a series of presentations to senior management and external groups on topics that became central to change at the WCB including disability management, the continuum of care, cost containment in rehabilitation, and managed care.

Change has been a constant at the Centre for the last few years. Evidence regarding changes in structure and programs have been discussed earlier, as well as the impacts on staff morale, and professional development requirements. This in itself demonstrates that the Centre is capable of determining needs and responding to the changing environment. It may also be a limiting factor in the organization’s ability to respond in the immediate future. Staff may well be ready for a period of stabilization before embracing more change.

Research Findings and Evidence

8.1 the Division has the ability to maintain or improve results

8.1.1 As noted elsewhere, the Centre has established PERU to collect results data.
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

8.2.1 As noted elsewhere in this report, the Centre has prepared strategic and business plans that include analyses of referral sources and processes, trends in client numbers, and staffing requirements. (p.3, WP118)

8.2.2 It has also developed a network of external providers, so that it can meet its goal of providing quality rehabilitation closer to home. Referrals are made to a preferred provider if one exists close to a worker’s home. The Rehabilitation Centre is used as a preferred provider in Richmond, a site for research and development, and as a prototype site for all external programs that the Centre supervises. As it has a residence, it also houses out of town workers where no local treatment is available. External providers are evaluated to ensure quality.

In correspondence with the commission, the Board noted that in 1993 it ‘implemented a pilot project whereby six private physiotherapy clinics were authorized to provide Work Conditioning ... the intent ... was to offer quality rehabilitation services that were close to the injured worker’s home. Corresponding with the increasing emphasis on clinical excellence and accountability, outcome monitoring was initiated from the outset. As of March 1998, the number of Work Conditioning program providers has grown to 67. In addition, there are 26 Occupational Rehabilitation providers, 8 Interdisciplinary Pain Programs and 66 Activity Related Soft Tissue Disorder providers. Clearly the network of external rehabilitation providers has increased significantly both in terms of number of providers and rehabilitation services offered.

The relationship between the WCB and its external network is one of a growing partnership ... the effective operation of the network is vital in ensuring the successful management of the continuum of care. To this end the ... Rehabilitation Centre programs are leading the way by being part of a centre of excellence in research, development and teaching. In addition to providing direct clinical services, the Rehabilitation Centre’s programs are intended to act as prototypes for all clinical rehabilitation services the WCB oversees in its external network. ... The network, however, needs to be evolutionary, able to respond to the challenge of continually improving services while keeping costs in balance ...’

8.2.3 The Centre has also established Memoranda of Agreement and fee schedules with the major groups of suppliers.

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

8.3.1 Again, data from PERU put the Centre in a good position to respond to changes. For example:
• Second quarter 1996: "Hand Program referrals from external sources were lower than expected ... Possible reasons include: surgery and therapy may be happening more frequently in local communities, and/or there were less serious traumatic hand injuries because of increased safety in industry, or fewer people working in industries such as forestry and fishing.” (p. 8-9, WP14)

8.3.2 In 1995-96, the Centre sponsored an evaluation on improving the utilization of services common to BC REHAB, the WCB and ICBC. This type of research helps the Centre continue and expand linkages with other rehabilitation agencies. (p. 17, WP14)

8.3.3 The 1997 Business Plan considers the excellent physical facility to be one of the Centre’s strengths. It has a wide range of in-house industrial facilities for assessment and treatment. No competitor can offer this kind of facility. (WP1) This would help to guarantee the survival of the facility, although it could also be managed under contract.

8.2.4 One of the CSF’s from the 1997 Business Plan concerns maintaining the Centre's status as the leader in this network of rehabilitation providers. This approach could be a factor in positioning the Centre with respect to competition from external providers. (WP1)
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

Conclusion

Hypothesis 9 is partially supported by the evidence reviewed.

Much of the information required to evaluate whether the criteria for this hypothesis are met comes from outside the Rehabilitation Centre itself. Corporate and Division level policies, procedures, and processes seem to dominate the financial management of the Centre. Consequently, much of the analysis is reported in the Overall Rehabilitation section of this report. A thorough investigation of this hypothesis would require access to a completely different set of evidence than the researchers had access to. However, none of the evidence reviewed suggests that the Centre is not setting and achieving its financial objectives in a responsible manner.

The 1995 CARF assessment report commented favourably on the Centre’s budgeting process and fiscal record keeping. CARF did not look at cost effectiveness or benchmark outcome and costs with other Rehabilitation facilities.

Research Findings and Evidence

9.1 the Division has set financial objectives

9.1.1 The Division, including the Rehabilitation Centre, considers the budget to be its statement of financial objectives. The Centre’s budgets in recent years have been included in the RCSD’s business plans. These plans present historical statistics as well as projections. (p.22, WP1)
9.1.2 Prior to inclusion in the RCSD, the Centre prepared its own budgets in accordance with its *Administrative Policy/Procedure Manual* (1995). Policy 4.21 requires the manager of a program to develop an annual budget with input from the following: goals and objectives of the staff planning group, the RC and Program Consumer Based Plan, focus groups, marketing guide, personnel development requirements, needs assessment review, the Centre’s strategic and business plans, the collective agreement, the quality management Committee and annual report, accreditation requirements, program and service personnel, program evaluation results, and satisfaction survey results. These budgets are to be reviewed by the Assistant Director prior to submission. (p. 4.21, WP106)

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)

9.2.1 The Rehabilitation Centre does not control the number of referrals. Consequently, it is difficult to predict referrals and use. In an interview, the RCSD Controller and the Manager, Finance and Administration noted that RCS Division uses Prevention Division’s targets for injury rate and fatalities. Prevention project how their activities may impact these figures; RCS Division use these projections to estimate claims costs, which are then built into the budget. They also examine trends and previous years’ activity levels and expenses. (p. 2, WP473)

9.2.2 Our analysis of PERU findings also indicates that performance results influence programming decisions and hence program budgets.

9.2.3 Expenditures for the period 1994-1997 plus budgeted expenditures for 1998 are shown in the following table.
Extracted from the 1996 WCB Business Plan, pp. 6-18 to 6-29: Rehabilitation Centre

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>1995</th>
<th>Increase (Decrease)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care ($,000s)</td>
<td>21658</td>
<td>22320</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1995 Budget</th>
<th>1995 Forecast</th>
<th>1996 Budget</th>
<th>Increase (Decrease)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FTE Summary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Operations</td>
<td>292.6</td>
<td>270.9</td>
<td>278.5</td>
<td>(4.8%)</td>
</tr>
<tr>
<td>Add maintenance</td>
<td>13.3</td>
<td>12.0</td>
<td>12.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>previously part of RC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>transferred to Facilities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>305.9</td>
<td>282.9</td>
<td>290.5</td>
<td>(5.0%)</td>
</tr>
<tr>
<td>Capital Budget</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Replace existing assets</td>
<td>1664</td>
<td>1128</td>
<td>236</td>
<td>(85.8%)</td>
</tr>
<tr>
<td>Invest in new assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strat.plan initiatives</td>
<td>380</td>
<td></td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1664</td>
<td>1128</td>
<td>616</td>
<td>(63.0%)</td>
</tr>
</tbody>
</table>

9.2.4 The budget presented in the statistical projections for the RC on p. 27 of the 1997 Business Plan show an increase for all programs with respect to treatment days. Unfortunately, there is no discussion supporting this table, describing why there are increases and how this is managed in the budget process. (p. 27, WP1)

9.2.5 Rehabilitation Centre expenses for 1995 were $20,710,000, similar to $20,757,000 for 1994. In 1995, salaries and employee benefits were 77% of the expenditures. (p.38, WP347)

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

9.3.1 In 1995, the Centre instituted direct billing to claims files for full cost recovery. The Centre was developing a common business infrastructure for all clinical programs. This would allow the centre to fully match revenues and expenditures. (p. 4, WP118)
9.3.2 In an interview, one of the Co-directors of the Centre stated that he “is comfortable with the level, accuracy and timeliness of budgetary information” that he receives. (p. 2, WP441)

9.3.3 See also the CARF review comments presented below.

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

9.4.1 There is insufficient data to comment on this criterion to-date.

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

9.5.1 There is insufficient data to comment on this criterion to-date.

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

9.6.1 The CARF report of 1995 stated, “There is a formal budgetting process that projects needed resources and is approved by the governing body. There is a comparison of projected to actual expenditures on a monthly basis and an assessment of accomplishment of budgetted goals. Appropriate fiscal records are maintained and there are periodic reports of the financial status of the Centre. A cost recovery system has been utilized with the appropriate fee schedules for the various service components provided. The charges are based upon both the direct and indirect costs of the services provided.” (WP117 p.3)

9.6.2 With respect to contracting out work, Request for proposal packages for Occupational Rehabilitation, Worksite Reintegration and Work Conditioning (Pilot) programs contained Proposal requirements, data/reporting requirements, and admission/eligibility. (WP282)

9.7 the financial information is subject to verification/audit

9.7.1 The Memoranda of Agreement and Fee Schedules for Worksite Reintegration, Occupational Rehabilitation, Medical Rehabilitation and Work Conditioning all have provisions for accessing providers’ premises and reviewing their records for the purpose of auditing WCB services. (WP280)
Hypothesis 10: THE DIVISION IS PROTECTING ITS ASSETS

CCAF attribute: 11

Evaluation criterion:

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

Conclusion

This Hypothesis 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 Centre is responsible for assets assigned to it and has instituted controls to ensure they are safeguarded.

Staff are also an organizational asset as both the means of pursuing the organizations goals and a repository for its history and culture. The management staff interviewed recognize this. In addition, a number of policies and procedures are in place that are designed to deal with staff orientation, employment equity, harassment, development, safety and security.

Information is not always recognized by organizations as a resource that requires management, as an asset that requires protection. In this case, there is preliminary evidence of this awareness. A data guardian is assigned at the Rehabilitation Centre to ensure that staff have appropriate access approvals for data.

The 1995 CARF accreditation survey examined the Centre’s asset control systems and made only one recommendation, regarding the need for closed shelving units.

Research Findings and Evidence

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

10.1.1 Responsibility for tracking and safeguarding the Centre’s physical assets rests primarily with Treasury Department and Facilities. (p.2, WP433)

10.1.2 Responsibility for tracking and safeguarding computer software rests with ISD.

10.1.3 The Centre is responsible for safeguarding and tracking other moveables assigned to it, such as computers, and materials and machinery in the workshops. One of the co-directors noted that there are extensive written protocols for how to remove things out of the workshops; if, for example, a client makes a picnic table, he/she has to pay for it,
get a receipt, and have the receipt checked by staff before picking up the table. Staff also cannot remove items without having them signed out.

10.1.4 One of the co-directors for the Centre noted that staff are very much considered an asset to be safeguarded. The Centre has set in place several policies and procedures to ensure staff are safeguarded. For example, staff get safety training; there are policies to deal with threats of violence and harassment; emergency panic buttons have been installed on certain desks; and there is training and awareness to ensure staff know about these things. (p. 5, WP442) Specific policies in the Centre’s Policy Manual include:

- a series of staff-related policies that deal with issues of recruitment and selection processes, staff orientation, employment equity, harassment, performance planning and review, and personnel development. (WP106:Sect. 3)

- a series of emergency, safety and health policies. Topics covered include: first aid services, emergency evacuation, threats of violence, disaster plan response, emergency planning test, infection control, use of smoking products and the health unit. (WP106:Sect. 5)

10.1.5 The Centre’s Administration Policy and Procedures Manual notes that the Rehabilitation Centre uses a team approach to quality assurance or quality management. One of the goals of the Quality Management Program is to help staff reach their full potential. (WP106:Sect. 7)

10.1.6 The Strategic Principles for the Centre include "focus on staff development, and increase staff input and involvement in the development of new practices."

10.1.7 As noted elsewhere in this report, the Centre has developed an external providers network and has entered into Memoranda of Agreement and set fee schedules for the major categories of suppliers.

10.1.8 The 1995 CARF accreditation survey examined the Centre’s asset control systems. It recommended that closed shelving units be purchased to ensure protection of the files from sprinkler heads in the file room. The Director at that time, in his response to these recommendations, suggested the current system be maintained for the following reasons:

- It would cost $25,000 to $60,000 and given the Board was planning to change soon to an e-file system this cost could not be justified .
- The sprinkler system in the file room was set to go off only if there is a fire in the actual records room.
- The files stored in the room were copies of the claim file with Rehabilitation Centre documentation attached . The original claim file that the Board is legally required to maintain is not stored at the Rehabilitation Centre. (WP 117)
Hypothesis 11: THE DIVISION’S AFFAIRS ARE CONDUCTED IN ACCORDANCE WITH LEGISLATED REQUIREMENTS AND WITH EXPECTED STANDARDS OF CONDUCT

CCAFC 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

Conclusion

Hypothesis 11 is supported by the evidence.

As noted in Hypothesis 1, there is no direct legal requirement for a Rehabilitation Centre. As far as we can determine, the Centre is complying with the relevant sections of the Act.

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 requires accredited organizations to adhere to certain principles. As elsewhere in the organization, FIPPA policies and procedures affect the confidential treatment of client data.

There are indications that the Centre is aware of potential issues with regard to access and equity for those with English as a second language.

No complaints of unfair or unethical conduct of the Centre or its staff by its clients or customers was presented to the researchers for review. However, we are advised from other sources that there is growing controversy regarding the WCB system of expedited referrals to specialists and expensive imaging studies. This puts WCB claimants ahead of the line of other citizens awaiting medical treatment and has been construed by some as the development of a two tiered medical system. WCB funding might be viewed by the larger public to be a source of inequity if WCB clients receive preferential service or access.

Research Findings and Evidence

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

11.1.1 Legislation: As noted in Hypothesis 1, there is no direct legal requirement for a Rehabilitation Centre. We have not discovered in our research any information to suggest that the Centre is not complying with those sections of the Act relating to the
provision of services and quality and conduct of medical staff, or with other authorities and legislation such as FIPPA.

11.1.2 As noted elsewhere in this report, CARF accreditation is an internationally recognized designation that assures clients a rehabilitation centre adheres to high standards of practice. CARF accreditation confirms that the programs at the Rehabilitation Centre have been independently surveyed and meet the professional standards of practice. CARF requires organizations to adhere to the following principles:

- Promote the basic human rights, dignity, health, and safety of the persons served.
- Demonstrate that the persons served are involved in the individual planning, decision-making, and implementing of the services they will receive.
- Provide services that are designed to enhance the independence, self-sufficiency, and productivity of the persons served.
- Provide coordinated, individualized, goal-oriented services leading to desired outcomes.

11.1.3 The 1995 CARF accreditation applied to three programs. In 1993, the plan was that “The time-based sequential treatment model should be set out, with the requirement that all service providers be licensed professionals, and all interdisciplinary programs be CARF- accredited by 1996.” (p. 4, WP422)

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

11.2.1 There is no specific code of conduct for the Rehabilitation Centre. Staff are expected to comply with the Board’s standards of conduct, and with the codes of ethics or the standards of conduct of their respective professions. They are also expected to comply with the secrecy requirements spelled out in Section 95 of the Workers’ Compensation Act, and with FIPPA requirements. In addition, CARF has some standards regarding how staff treat injured workers. (p. 6, WP442)

11.2.2 The Memoranda of agreement for Medical Rehabilitation and Worksite Reintegration programs specify the providers’ responsibilities with regard to freedom of information, confidentiality, conflict of interest and resolution. The Occupational Rehabilitation and Work Conditioning Memoranda do not include FIPPA information. (WP280) However, the Work Conditioning Program policy refers to both FIPPA requirements and the Standards of Practice of the College of Physical Therapists of BC. (p. 5.0, WP281)

11.2.3 With respect to access, the admission criteria for the Rehabilitation. Centre are included in the 1993 Administrative Inventory. (p. 31, WP252)

11.2.4 In an interview, one of the Centre’s co-directors stated that "All workers have equal access." Programs have admission criteria and there are no real waiting lists. He did not mention whether a general severity rating is used. (p. 4, WP442)
11.2.5 The 1996 Compensation Services Business Plan notes: "In conjunction with the Rehabilitation Centre, further development of such programs [local work conditioning] will be encouraged in communities not yet served by local programs. Alternatively, strategies to ensure expedited Rehabilitation Centre admissions for clients from underserved communities will be implemented." (p. 50, WP300)

11.2.6 As noted elsewhere, the Centre is providing services closer to home through its network of external providers.

11.2.7 With respect to language of service, 1994 Leslie R. Peterson Client Survey states, "It is evident that a significant minority of clients do not speak English as their main language." (p. 9, WP453) In a similar vein, the 1995 Hand Unit Annual Report: Outcomes of Hand Unit Clients Discharged in 1995 notes: "a quarter of Hand Unit's 1995 clients indicated that they did not speak English at home. Most of these clients said that they spoke Hindi, Punjabi or Gujarat, with Chinese/Cantonese being the next most common language named." (p. 16, WP476)

11.2.8 In an interview, one of the Centre’s co-directors stated that approximately 20% of Centre clients have language difficulties, although almost all have some English. In their follow up surveys, Angus Reid can get answers from approximately one-third of this 20%. They do not necessarily get a good answer from the remaining two-thirds; where possible they ask if a family member can help.

He also noted that it is very difficult for Centre staff to offer seminars to people without functional English. They can do demonstrations but at the Pain Program for example the work is primarily education and they sometimes need translators in the room. The Centre has hired translators but finds this is very disruptive for the entire group.

They approached Columbia Rehabilitation, an external provider on the Langley border where there are many workers of Punjabi origin, to put together a team of a physician, psychologist, occupational therapist, physiotherapist and vocational rehabilitation specialist who speak Punjabi. The many claimants in that area who speak Punjabi but not English are referred there. “This is the ideal world." (p. 4, WP441)

11.2.9 In-service on Sikh culture is available to URC's Claims Officers, Claims Adjudicators, Psychologists and RC therapists. (p. 11, WP417)

11.2.10 In an interview with one of the Centre’s co-directors we were advised that the Manager of the Residence for the Centre has developed pamphlets in different languages. (p.4, WP442)

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
11.3.1 The issue of satisfaction is dealt with at length in Hypothesis 6.
APPENDIX 8

Brief Outlines of Rehabilitation-related Studies in or Concerning BC

HRDC: CPP Disability Benefits: National Vocational Rehabilitation Program

The 1996 evaluation reported on the effectiveness of the National Vocational Rehabilitation Project (NVRP) and examined the feasibility of operating a permanent rehabilitation function as part of the CPP Disability program. The report found that significant cost-savings are possible, even with the rehabilitation of a small portion of CPPD beneficiaries, and that rehabilitation is an effective caseload management mechanism used by most other providers of disability insurance. Since the evaluation, vocational rehabilitation has been enshrined in legislation and has become an ongoing part of CPP’s business. This is a national program and applies to Canada generally.

The project was successful in returning a significant number of CPPD beneficiaries to regular employment. At the time of the study, of the 42% of NVRP clients who had successfully completed their rehabilitation plan, about 60% had subsequently found employment. ‘Multivariate statistical analyses suggest that the NVRP is an important factor in rehabilitation and subsequent employment and that in contrast, only a very small proportion of beneficiaries leave CPPD for employment on their own (without NVRP).’ (WP298, p.iii, 81)

Total costs per client (including costs incurred for non-successful clients and administration) were recovered within two years of a successful completion of rehabilitation. However, the evaluation notes: ‘there is a need for implementing better processes to track the long-term impacts of vocational rehabilitation as potential cost savings are linked to the continuing financial independents of NVRP participants.’ (WP298, p.iii)

Survey results indicated that ‘there can be good potential for rehabilitation for some CPPD beneficiaries, even after several years on benefits, as the medical condition stabilizes and adjustments to accommodate disabilities have been made.’ (WP298, p.vi)

Rehabilitation services were provided by a third party delivery system. While this allowed for ‘flexibility in service delivery’ and securing ‘specialized professional resources’, ‘project data indicate that the performance of outside contracts is highly varied.’ The issue is ‘to find the appropriate balance between contracting out and internal delivery of services.’ ‘A mixed system could be considered, where in-house case managers are supplemented by contract suppliers on an as-needed basis to ensure flexibility to adapt to changing caseloads.’ (WP298, p.vii)

Correlates of successful rehabilitation were examined statistically; the factors that showed some correlation with successful return to work included: few activities limitations, fewer needs for assistance, higher levels of education, prior attempts to find work while on CPPD, non-receipt of the dependent child benefit, and self-reported potential for rehabilitation. ‘Somewhat
surprisingly, longer periods on CPPD benefits are correlated with successful return to work.’ (WP298, p.vii)

Client satisfaction was determined through a survey. A number of recurrent concerns were expressed by survey respondents including lack of consideration given to career goals, and non-delivery of services that had been promised. These data point to the need to emphasize communications throughout the rehabilitation process and to ensure that clients’ expectations are not unrealistic. (WP298, p.vii)

A majority of beneficiaries whose benefits 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)

Participation in the NVRP was voluntary. Rehabilitation consultants noted that NVRP clients tended to be more motivated than their other clients, a fact which they linked to the voluntary aspect of the program. (WP298, p.ix)

More than half of the survey respondents indicated that they were in receipt of co-benefits from other services providers (e.g. Workers’ Compensation Boards, private long-term disability insurance). However, cost-sharing agreements were developed for only a small proportion of them. The evaluation concluded that there is potential for greater complementary efforts between NVRP and other vocational rehabilitation services providers. Current constraints to this included lack of harmonization between public and private disability insurance programs with differing eligibility criteria, definitions of disability and program goals; possible cost implications for other service providers when CPPD benefits cease; the need for confidentiality of CPPD beneficiary files; differing or competing case management structures between providers; and an apparent lack of knowledge of NVRP on the part of other service providers.’ The evaluation identified a need for increased initiatives to co-ordinate CPP rehabilitation efforts with other service deliverers and to negotiate partnership agreements with other service providers. These agreements would ideally define the parameters for sharing costs and case managing common clients. (WP298, p.ix-x)

The cost of the CPPD program increased sharply during the early 1990's, which created substantial financial demands on the CPP fund, causing the disability component to represent a larger share of the total CPP expenditures. Cost savings resulting from the successful rehabilitation of even a small portion of CPPD beneficiaries (especially younger individuals) can be significant. Survey results indicate that the average annual pension paid to NVRP clients is about $8,760. Therefore cost-savings from the successful rehabilitation of a single client at age 45 can amount to as much as $175,200 by time of transfer from CPPD to CPP retirement. (WP298, p.21)

‘According to project data, the successful rehabilitation of the 160 clients who completed their rehabilitation plan to date would yield cost-savings of $4.5 million after three years, $15 million after ten years and about $30 million by the time rehabilitated clients reached the age of 65, if they
do not return to the disability rolls. These numbers represent the dollar value of benefits saved and do not include other forms of savings for CPP such as increased contributions. Also not included are other indirect financial impacts for the government such as increased income tax revenues or reduced/increased dependence on other income support programs, etc., or non-monetary social development benefits.’ (WP298, p.iv)

‘As a rule, total project costs for a client are currently recovered within two years of a successful completion of rehabilitation, thus indicating that potential cost-savings for CPPD as a result of NVRP could be substantial.’ (WP298, p.73)

About 60% of project participants who completed their rehabilitation found employment... Most participants indicated that they would have found employment regardless of NRP, but these beliefs in self-generated success are contradicted by other analyses of survey results’ (WP298, p.81)

**ICBC**

An important factor that affects the philosophy and perspective that auto insurance providers have towards early intervention and rtw is whether the system is an injury compensation of ‘no-fault’ model as found in Quebec, Manitoba and Saskatchewan, or a common law (tort) adversarial system that allows claimants to file suit, as in BC, Alberta and to a limited extent Ontario. Under a tort law system, insurance providers are encouraged to close a claim as quickly and inexpensively as possible. This can impose nearly insurmountable barriers to early rtw. If a suit is filed, the injured person’s desire to rtw can be compromised until the claim is settled. From the time a suit is filed, the injured person has little or no communication with the insurer. This encourages the insurance provider to focus on controlling litigation costs rather than on the more positive goal of effecting an early recovery and safe rtw.

The key benefit ICBC perceives in moving to an injury compensation model is that it will allow all parties involved in an auto injury to focus on wellness and ensuring that the injured motorist is provided with the best treatment known and available to ensure recovery. ‘Under an injury compensation model, the claims adjusters can focus on encouraging and supporting rtw; injured motorists will receive more equitable and consistent benefits’.

In the recent past, the move towards early intervention and active recovery management across Canada has neglected the role of the employer and union in supporting an early rtw. Under an adversarial, tort law system, employers and unions have little impact on a worker’s recovery or rtw. Under an injury compensation system, when the focus of rtw efforts can be on the injured motorist rather than simply on controlling costs, employers and unions can support the successful rtw by developing workplace disability management programs. An injury compensation model will provide greater incentive for the insurance provider to work collaboratively with workplaces that can offer transitional or GRTW options. (Adapted from an article by the Senior Vice President, Operations, ICBC, in the NIDMAR report Strategies for Success. WP448, p.188-191)
BC has the worst crash rate in Canada; claims costs have been climbing steadily. The major factor behind the escalating costs is injury claims: during the past 10 years, the cost of personal injury claims has increased 187%.

Researchers at ICBC studied what was taking place in other cities, provinces and countries. Their findings indicated that ICBC should shift focus to encourage injury prevention and to improve rehabilitation of injured drivers. Of the 117,800 injury-related claims in 1996, more than 70% were soft-tissue injury claims. ICBC analyzed the characteristics of these claims to determine probable solutions.

Most soft-tissue injury claimants recover fairly quickly and return within 30 days. However, 25% do not recover quickly; this small group of soft tissue injury claimants account for most of the more than $400 m that ICBC pays out for soft tissue injuries. Statistics show that more and more people with soft tissue injuries are becoming chronic cases. In 1996, permanently disabled claimants made up 9% of the total claims but accounted for 49% of total payments made. ICBC developed a new program to help this group: the Soft Tissue Injury Recovery Management Program (RMP). It is based on: early intervention; an active recovery program involving the patient; and an early return even when chronic pain is involved.

If an injured motorist is unlikely (at first meeting with adjuster) to return within 30 days, or has not done so by 30 days, then he/she is referred to RMP. A case coordinator, typically an occupational therapist or physiotherapist, contacts the injured motorist and the treating physician and develops a detailed recovery plan. The case coordinator maintains regular contact with the treating physician and monitors the progress of each recovery program, checking progress at least at 30 day, 90-120 days and 180 days. If the RMP encounters roadblocks, the case coordinator is responsible for finding ways around them. There are detailed guidelines for case coordinators that describe anticipated timelines and performance standards.

This program represents a significant change in the way ICBC carries out its mandate. ICBC is investing in the patient’s recovery instead of waiting to see how the patient recovers and then paying out the costs involved. It is a more proactive, positive approach that can only work with the support and involvement of the patient, physician, case coordinator, employer, service providers etc.

Early results show that with the RMP there are 20% fewer soft tissue injury claimants becoming chronic. This seems to indicate that people are getting better faster. An unexpected benefit discovered in pilot programs is that the program helps identify serious injuries early in the recovery process. Where the program has been implemented, the medical community has accepted it. (Adapted from an article by the Manager, Recovery Management Support ICBC, in the NIDMAR report Strategies for Success. WP448, p.193-200)

**Disability Management Case Studies**

The following three case studies relate more to the impact of disability management than to vocational rehabilitation. However, they illustrate the impact that employer support and
willingness to accommodate, on the part of both the worker and the employer, can have in terms of successful rtw outcomes. The successes reported by these two organizations have apparently been reported within several other corporations and organizations.

1. **BC Hydro**: During the first 15 months of the pilot disability management project, frequency and duration in absences declined; workers’ compensation premiums reduced by $700,000 in 1996 alone. (WP451, p.16)

2. **MacMillan Bloedel Somass sawmill**: Of the 120 workers who participated in disability management programs; 112 successfully returned to work, most to their pre-injury job. Workers’ compensation disbursements were reduced by 50%, and the number of workers receiving workers’ compensation benefits reduced from 37 to 5 in 1996. The program’s coordinator and staff estimated that assisting 14 workers who had been on long-term disability to rtw represented a net present day value savings of $2.486 million. (WP451, p.16)

3. **MacMillan Bloedel Alberni Specialties Division**: Before its disability management program, the Division’s long and short-term disability costs were three times the industry average. As of July 1996, it was given a one month’s premium ‘holiday’ on long-term disability and a two month premium holiday on short-term disability, due to the improvement in rtw outcomes. The Division will realize $1.25 million savings in one year. (WP451, p.16)

The characteristics of a successful disability management program include:

- a joint disability management committee with equal numbers of worker and management representatives;
- adequate training of committee members, with leave by the employer for attendance at training sessions;
- the development of ‘jointly-owned’ objectives, anticipated outcomes and procedures; and
- one or more disability management coordinators, selected by the committee, and responsible for maintaining contact with injured or ill workers, coordinating stakeholders, monitoring and assisting with the steps in each worker’s rtw; development of functional job assessments; and finding creative job opportunities, including gradual or transitional rtw. (WP451, p.13)

### Provincial Rehabilitation Planning Process

The Provincial Rehabilitation Planning Process was launched in the spring of 1994 to identify guiding principles for rehabilitation services, priority issues and actions. The project includes rehabilitation services which directly receive Ministry of Health funding and is thus focused more on medical rehabilitation than on vocational rehabilitation. The project used a variety of strategies and resulted in several reports.
Improving Rehabilitation Services in BC, the summary report, notes that each year there are more people with disabilities in British Columbia. All of these people will require rehabilitation services at some time. Although medical advances have improved the survival rate of individuals with severe injury or disability, services to enable an individual to do the things they want to do over their lifetime have often been fragmented and uncoordinated. ‘The provincial rehabilitation system has never been formally organized as a system but has evolved into the patchwork of services that exists today.’ (WP354, p.3)

The project found that rehabilitation provides economic payback when investments are made to optimize the development, recovery or ability of people with disabilities. While ‘statistics from Canadian sources are not readily available’, the report cites a US study by North Western National Life which showed ‘an average savings of $35.00 in long-term disability reserves for every dollar spent on rehabilitation’. Despite the potential for savings, changes in the need for rehabilitation services and constraints on health care spending make it imperative that stakeholders carefully plan future rehabilitation services.

‘Stakeholders consistently expressed that provincial coordination must occur to ensure that initiatives such as the development of rehab service inventories and databases are compatible across regions. This will facilitate service integration and communication across regions as well as eliminate the need for individuals and agencies to use scarce resources to duplicate systems development. (WP331)

‘Rehabilitation is an investment in people — where the benefits should outweigh the expenses. Rehabilitation services must be prepared to demonstrate the value of the outcome(s) of rehabilitation to the taxpayer.’ A footnote clarifies that ‘the principle of cost-effective is to work towards increasing the “value of the service provided for the dollars used” rather than “limiting service in order to avoid spending money”.’

Priority issues include:

- develop and implement rehabilitation case management, to ensure that the right service is provided to the client at the right time and in the right place in order to achieve his/her goals; and
- develop and implement rehabilitation information systems: the workshop participants identified the lack of, inconsistent quality of, and variable usefulness of data.

The report recommends the establishment of four data bases, including one on clinical service utilization and outcomes. The data bases should be linked.

**Returning to Work — Removing the Barriers**

The Returning To Work — Removing the Barriers pilot project was aimed at improving return-to-work outcomes for clients with disabilities. The project used a unique interagency approach to
vocational rehabilitation, an approach that emphasized collaborative case management. Phase II of the evaluation study — Review Of The Legislation, Policies And Practices Affecting Partners — reviewed the legislation, policies and practices related to four of the partners: HRDC - Canada Pension Plan (CPP), Insurance Corporation of BC (ICBC) (Part 7 Benefits and not its tort benefits), Manulife Financial (MF) and Workers Compensation Board of BC (WCB). Issues addressed in the summary report include:

- the legislation, policies and practices under which they operate;
- the benefits and services they provide;
- the eligibility criteria for these benefits/services;
- the coordination with, and implications of, other benefits and services; and
- the termination and reinstatement of benefits/services.

The following table is compiled using data extracted from this report.
### BENEFIT/SERVICE

<table>
<thead>
<tr>
<th>SERVICES PROVIDED</th>
<th>WCB</th>
<th>ICBC</th>
<th>CPP</th>
<th>MF</th>
</tr>
</thead>
<tbody>
<tr>
<td>-disability benefits/pensions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>-medical</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-vocational rehabilitation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

### MEDICAL

| -surgical, hospital, ambulance, nursing | X | X | | |
| -physiotherapy, occupational or speech therapy | X | X | | |
| -prosthetic, orthotic, assistive (aids and) devices | X | X | | |

### VOCATIONAL

| -range of services | X | X | X | |

### ELIGIBILITY CRITERIA

**Disability Benefits/Pensions**

| - age (<65) | X | X | X | |
| - the demonstrated existence and extent of client’s disability (may include vocational impacts of disability and its duration) | X | X | X | |
| - the timing of application vis a vis a critical event (e.g. a motor vehicle accident or disability onset date) | X | X | X | |
| - ineligible if e.g. injuries a) incurred while participating in an illegal act, b) self-inflicted, c) resulted from a ‘pre-existing’ condition | X | X | | |
| - long-term benefits require demonstrable evidence of severe and/or prolonged (un)employment impacts | | X | | X |

**Medical**

| - benefits must be considered necessary by qualified practitioners | X | X | | |
### Vocational Rehabilitation

- same eligibility criteria as for Disability Benefits/Pensions | X | X | X
- client is medically stable | | | X
- a potential for vocational rehabilitation exists | X | X | X
- client is motivated | | | X

### LEVEL OF BENEFITS

#### Medical

- medical benefits/services not covered if other provider also paying or reimbursing them | X | X | X
- medical benefits/services covered only if they are not covered under another plan or payable by another insurer | | | X
- benefits coordinated with other plans which also cover an insured person for similar benefits – such that no more than 100% of eligible expenses are paid for | | | X
- additional health care, when a worker is receiving benefits from another health care plan | X

#### Receipt Of Benefits/Services While Employed

- benefits terminate upon regained capacity to regularly pursue substantially gainful employment, but may continue while undertaking vocational rehabilitation programs and continue for the first three months of employment as a trial work period | | | X
- benefits continue if client has returned to work, but is incapable of earning an amount equal to his/her disability benefits payable (though employment income may be partly or fully deducted from his/her benefits payments) | X | X
- benefits continue while an employee earns rehabilitation income, but are reduced: to 50% of rehabilitation income (or up to 100% of pre-disability income) or up to 75% of monthly earnings in their (new or) normal occupation | | | X

### TERMINATION OF BENEFIT/SERVICES

- benefits/services are terminated once client starts to work again or becomes completely employable | X | X | X | X
### Disability Benefits/Pensions

<table>
<thead>
<tr>
<th>Condition</th>
<th>X</th>
<th>X</th>
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<tbody>
<tr>
<td>· at age 65 all benefits cease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· death</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>· disability ceases (medically)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>· employment starts/is reinstated; or rehabilitation plan completed/</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>employability reinstated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· uncooperative participation</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

### Vocational Rehabilitation

<table>
<thead>
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<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>· as for disability benefits/pensions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· client’s rehabilitation plan completed (irrespective of outcome)</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>· insufficient progress (for medical or motivational reasons)</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
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</tbody>
</table>

### REINSTATEMENT OF BENEFITS/SERVICES

<table>
<thead>
<tr>
<th>Condition</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
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</thead>
<tbody>
<tr>
<td>· allowed</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>· ‘fast-track’ reapplications, but client must requalify in terms of</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>both contributory and medical criteria</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· client may reapply and must continue to meet ICBC’s eligibility</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>criteria</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>· client may have to reapply, depending upon timing and whether or</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>not there has been a “recurrence” of the initial disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· client’s claims may be reopened for additional benefits/services</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>related to the same injury</td>
<td></td>
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</tbody>
</table>
APPENDIX 9

Workers’ Compensation Abroad: Selected Cases

This appendix presents additional information on Germany, Australia (Comcare), New Zealand, the US, Oregon, Texas, Wisconsin and Washington. The data comes from a variety of sources and illustrates some of the major differences found in the various systems.

Germany

The philosophy underpinning Germany’s approach to disabled persons and its workers’ compensation system is that ‘persons with disabilities should not be pushed to the margins of society ... the aim is to integrate persons with disabilities into all aspects of society ... independence and participation in society through meaningful work ensure economic existence, influence an individual’s self-esteem and define a person’s place in society, thereby enhancing quality of life. Persons with disabilities have a great deal to contribute to society.’ (WP448)

The German system recognizes the necessity of allowing employers to decide whom to hire or fire in order to remain competitive and financially profitable. On the other hand, it recognizes that integrating disabled persons into working life is a task not only for the single employer or for the community of employers, but for the whole society.

Under the Severely Disabled Persons Act, public and private employers have to fill 6% of their posts with severely disabled persons or pay a compensatory levy. The compensatory levy is not intended to be coercive but rather to act as an equalization mechanism. Employers who hire severely disabled persons often incur additional costs; the levy ensures that the financial costs of increasing the employment of severely disabled persons is spread equally among employers. Levy revenues may be used to provide wage cost subsidies, to provide loans or grants to employers who create jobs and training places; to modify work sites or install technical aids etc. One unfortunate disadvantage of a quota/levy system is the need to ‘label’ disabled persons. This labeling is seen as ‘positive discrimination’.

The quota/levy system is an attempt to change the labour market to provide favourable conditions for employment of disabled persons without intervening in the decision-making powers of employers. This system, together with other legislation and programs, has allowed Germany to achieve a relatively high level — 85% — of employment for disabled persons for whom employment under ordinary labour market conditions is possible.

It is against this backdrop that Germany’s workers’ compensation system works. This system is the oldest workers’ compensation system in existence and traces its roots to medieval times. It goes well beyond most by covering all private employees, apprentices, family helpers and even students (WP266d appendix p.4). It is decentralized along industry lines and administered by non-profit employer/employee Industrial Injury Insurance Institutes. Each institute has four major functions, including medical and voc. Organization by industry allows for a focus on the accident, medical, and loss control issues relevant for that industry. Rehabilitation is an explicit
goal. Involvement of employers and employees in governing the institutes reduces the adversarial nature of relationship. It covers all workplace injuries but limits occupational illnesses to a schedule of 55 diseases.

For the first 18 days, comprehensive medical services for workers’ compensation claims are provided by the national health care system unless the injury or illness is very severe. When injuries are very serious and medical care and are expected to last more than 18 days, the relevant institute assumes care, often in institute owned hospitals.

With respect to disability benefits, employers must continue the worker’s salary for the first 6 weeks, after which time the Institute pays 80% of salary until the worker has recovered or been certified as permanently disabled.

Vocational rehabilitation includes all forms of assistance necessary to help disabled persons find jobs that suit their abilities. Vocational assistance is available for disabled persons and potential employers and includes, for example,

- assistance in finding and maintaining employment;
- benefits for employers to encourage hiring of disabled persons;
- integration assistance for employers;
- vocational adaptations; and
- further education, training and retraining.

Experience has shown in Germany that vocational qualification is the key vocational integration instrument. There, emphasis is on training in the workplace; but there are also workshops available to severely disabled persons who cannot obtain employment in the general labour market. ‘Although it is expensive to provide training and retraining ... it is at least as expensive for society to provide social assistance for a disabled person’s lifetime. By providing good vocational training/retraining once, we have a working member of society who pays taxes. A disabled person who is integrated into working life is not excluded from society ....’ (WP448, p.15)

To assist vocational rehabilitation, the REHADAT data base was compiled. It contains more than 2,000 practical examples of successful vocational integration and other useful information concerning relevant laws, research, literature, technical aids etc. This data base has since been adopted by the National Institute of Disability Management and Research in Canada and a Canadian version, REHADAT CANADA is available.

**Australia**

Australia has 10 workers’ compensation systems. Comcare, the subject of this research, is one of them and it serves the employees of the federal government. It implements the Commonwealth Employees’ Rehabilitation and Compensation Act of 1988 (the word Commonwealth was
removed in 1992). This legislation emphasizes the implementation of strategies to manage the return to work process for injured employees.

As of July 1, 1989, all Commonwealth agencies (departments, statutory authorities and government-owned enterprises) became financially accountable for the cost of work injuries through the payment of a premium to Comcare to cover the full cost of workers’ compensation. With respect to rehabilitation, these agencies were expected to manage their own insured risk; to take responsibility for the health and safety of their workers; to cooperate with Comcare in establishing practical rehabilitation arrangements; and to pay premiums each year.

A **case manager** is responsible for managing a worker’s rehabilitation. Every workplace must have a case manager, appointed by the insured employer and trained by Comcare. The case manager represents the employer and is involved in joint decision-making with the injured worker in matters relating to the program of rehabilitation. Employers are beginning to recognize how important the case manager’s role is.

The **injured worker** has a number of responsibilities in the return to work process that include active participation in:

- the preparation of the return to work plan;
- completion of a treatment program developed by medical practitioners (chosen by the worker);
- return to work activities such as work trials, alternative duties, rotating duties, injury prevention training; and
- reporting of any further problems.

The **doctor**, usually the worker’s treating practitioner, plays a crucial role, both through treating the injury and in supporting the return to work process by providing medical clearances. Comcare encourages close participation by medical professionals (doctors, occupational therapists, ergonomists, physiotherapists etc.) in return to work planning.

**Providers** must be approved by Comcare, and are evaluated using the following criteria:

- efficiency of service provision;
- availability of services;
- cost of services; and
- return to work performance.

Providers that do not meet Comcare standards are removed from the Approved Providers list. A provider’s role has less to do with treatment and more with the workplace, home environment and personal difficulties. This reflects the holistic approach.

The **injured worker’s supervisor** should ensure that the job duties and requirements match the abilities of the injured worker; and ensure any required workplace or work practice changes are completed. The supervisor should also ensure that co-workers accept the return of the injured worker.
The union’s role is to assist the injured worker through the return to work process.

Co-workers should provide support to injured workers, both in a working and a social context. They can also assist with on the job training.

Comcare Australia has a leading role:
- A program of rehabilitation must be developed for every injured worker who is expected to be off work for more than 10 days. This early warning system allows rehabilitation to begin as soon as possible.
- Once a claim is lodged, the employing agency is informed of any decision taken.
- A return to work plan is developed that sets goals and defines actions necessary to attain those goals. Each plan sets out time frames and costs and is the basis on which all parties are paid. The return to work plan is signed by the worker, employer (usually the case manager) and the approved provider if used.
- It ensuring benefits are paid.
- It provides training for case managers, and monitors all case management or plans etc.

Since 1988, Comcare has established an enviable record of achievements:
- Its premium rate is the best in Australia for similar schemes and benefits.
- The number of claims where time off work extended beyond four weeks has been halved.
- It achieves an 88% return to work rate.
- 85% of all new claims are now processed in 10 days.
- 90% of simple claims are dealt with in two days.

This success has largely been achieved by working in partnership with managers, employees, unions, service providers and other stakeholders.

In September 1993, members of the 10 Australian workers’ compensation regulators embarked on a five year plan to achieve national consistency and best practices.

New Zealand

Since 1974, New Zealand’s accident compensation scheme has provided 24-hour no-fault personal accident insurance to all New Zealanders and visitors to New Zealand. It offers wider coverage than traditional workers’ compensation schemes. It is based on 5 principles:
- community responsibility;
- comprehensive entitlement;
- complete rehabilitation;
- real compensation; and
- administrative efficiency.
'Complete rehabilitation’ means ‘every injured person should be encouraged to recover the maximum degree of bodily health and vocational utility in the minimum time’. (WP266d p5)

Although the system does not distinguish between work-related and non-work related injuries, it does distinguish between work-related and non-work related illnesses, with coverage provided only for the former. Financial compensation for accidents is viewed as part of the process rather than the major focus of the system.

The scheme is administered by the Accident Rehabilitation and Compensation Insurance Corporation (ACC). Its goal is to reduce the social, economic and physical impact of personal injury on individuals and the community by:

• implementing effective injury prevention programs;
• ensuring effective intervention when injury occurs to ensure appropriate treatment is received;
• working with claimants to help them return to independent living and employment as soon as possible, where practical; and
• ensuring equitable funding of the scheme.

The scheme is funded through various accounts, for example:

• the Employers Account, which covers the costs associated with people injured through work-related injuries; it is funded through a premium charged on wages and salaries paid by employers; and

• the Earners Account, which covers the costs associated with injuries occurring to salary and wage earners outside the workplace (aside from injuries associated with motor vehicle accidents); it is funded through a premium on earnings.

Benefits include assistance with medical treatment and rehabilitation through both the public and private health systems, social rehabilitation and vocational rehabilitation.

The average cost of the scheme in 1995-96 was $445 per head of population per annum. While the scheme has wide support, consumer groups are critical of the benefits, and premium payers are concerned with burgeoning costs.

Some of the problems that were encountered as the new scheme grew, and with the restructuring of the New Zealand economy starting in 1984 on included:

• lack of legislative tools for effectively returning people to work;
• lack of accountability for purchase of medical services from the public health system; and
• insufficient employer involvement in return to work efforts: there was no requirement on the part of the employer to re-employ an injured worker, to provide or to restructure the work environment.
Amending legislation passed in October 1996 was designed to address these and other key problems. It:

- resolved the medical accountability;
- strengthened return to work efforts by enabling the ACC to undertake work capacity testing and retrain injured workers in a different occupation if unable to return to their former employer;
- emphasized the role of employer; areas in which employers can play an active role include clearly identifying job requirements to enable early and safe return to work, and developing return to work options to allow injured workers to be reintegrated into the workplace while continuing their recovery.

New Zealand’s accident compensation scheme is considered to provide a unique social insurance solution to the management of personal injury caused by accidents in the workplace or in the broader community. (WP448 p 45-53)

US

There are three workers’ compensation models in the US: 23 states have private insurance, 21 states have competitive state insurance, and 6 states have monopolistic state insurance (like Canada). (WP266d p.18ff)

Over 60% of all US states have launched reform efforts since 1989: 26 states introduced major reforms 1989-93; and 10 were in the process of developing reforms as at 94. Fourteen states are considered healthy: some of these had introduced reforms prior to 1989. (WP266d p.37, 45)

Among the 26 states enacting reforms in the 1989-93 period, seven major issues have driven the reform efforts. These include soaring medical costs, which is reflected in the fact that 40% of reforms focus on managed care, 36% on maximum medical fee schedule, and 36% on limited physician choice. In addition, 12% states reforms included a definition of maximum medical insurance. While vocational rehabilitation is not among the major issues, return to work is a focus of reform in 24% states, and a tightening of vocational rehabilitation is a focus in 12% of states. (WP266d p.38-9)

In addition to reforms made or underway, 13 states have begun to consider 24-hour coverage. Two of these, Oregon and California, launched pilots in 1994. The benefits of reductions in costs, administration and litigation (related to ‘cause’) may be offset by the cost of additional coverage and the problems of creating a single claims handling system. (WP266d, app. p.30)

A significant piece of legislation affecting the employment of persons with disabilities is the Americans with Disabilities Act passed in 1990. The ADA attempts to prevent discrimination on the basis of disability in such areas as employment, education, and access. While employers do not have to give preference to persons with disabilities or hire a certain number of persons with
disabilities, they cannot refuse employment to a person with a disability as long as the individual is qualified and able to perform the essential functions of a position with or without reasonable accommodation. Generally, the ‘essential functions’ are those identified in a job description before a job is advertised and interviewing begins. A ‘reasonable accommodation’ is any modification or adjustment to a job or work environment that will enable a qualified applicant or employee with a disability to perform essential job functions. Accommodations ensure that a qualified individual with a disability has the same rights and privileges as persons without disabilities. An employer is not required to provide an accommodation if it would impose ‘undue hardship’ or significant difficulty or expense to an employer. This is assessed on an employer-by-employer basis.

Since the ADA was passed, many positive changes have occurred. ‘Most employers recognize their obligation .. many have made accommodations and found that they are rarely as expensive as was feared prior to passage of the ADA’. Studies completed in 1986 and 1992 show that more than half of the accommodations made cost nothing, while 15% cost under $500. Tax provisions allowed certain employers to claim deductions or tax credits for accommodations. Despite this progress, approximately two-thirds of the population of people with disabilities in the US who are looking for work are not employed. The ADA helped: but ‘it is now apparent that discrimination is only one aspect of a complicated mix of variables that inhibits labour force participation by people with disabilities.’ (WP448:69)

**Oregon**

In the mid 1980's the Oregon system was one of the highest cost systems in the US, and inadequate levels of permanency benefits. All sides agreed that major reform of the system was inevitable.

Major reforms were introduced in 1987 and 1990, with other changes in 1992, 1993 and 1995. These reforms touched all major aspects of the system: including encouraging return to work, restricting eligibility for vocational assistance, limiting palliative care, limiting the role of the chiropractor as treating physician, permitting managed care ...

Despite some good changes, and the fact that he Oregon workers’ compensation system today is widely regarded to be the most successful US reform effort, (WP266d p.40) ‘labor representatives are not satisfied with the current law and the level of some benefits ...’ (WP300 p.xv)

The reforms relevant to this present research include:

- restricting the compensability of mental stress claims to those that arise out of real and objective work conditions that are not inherent in every work situation and by requiring ‘clear and convincing evidence’ that mental disorders arise out of and in the course of employment, in an attempt to lower claim frequency
- two major changes were made in the area of return to work:
  - first, in response to rising concerns over its effectiveness, eligibility for vocational assistance was substantially restricted; and
second, the Preferred Worker Program (PWP) was created to encourage employers to hire workers with disabilities that are not the product of compensable injuries.

• with respect to medical cost containment:
  • reducing the number of attending physicians a worker can choose over the life of a claim from five to three, and restricting limited insurers and self-insurers to three medical examinations for each claim opened;
  • empowering the director of the DIF to establish a fee schedule for specific inpatient hospital services and to restrict the compensability of medical treatments that are unscientific or unproven;
  • prohibiting the introduction of new medical evidence subsequent to a medical arbiter’s report (‘freezing the record’), thereby limiting litigation over initial claim closure by ensuring all parties would be addressing the same issues using the same evidence; and
  • charging the medical director to enhance communication among policy makers and health care providers in Oregon, developing and implementing treatment guidelines for high-cost workers’ compensation conditions.

• with respect to vocational assistance:
  • requiring insurers and self-insurers to provide vocational assistance to any eligible worker. Insurers and self-insurers are responsible for evaluating the worker’s eligibility; the selection of a provider is by mutual agreement. Workers or workers’ representatives are supposed to participate in the selection process. If an injured worker objects to a provider, the services suggested by a provider, the nature or extent of vocational assistance, or his or her eligibility status, the matter is taken to the division’s Rehabilitation Review Unit; and
  • modifying reinstatement rights for workers by making an employer responsible for providing a worker with reemployment if the worker’s old job or alternative suitable employment is available. By law, workers are eligible for reinstatement if they have not refused a certified offer of light duty or if they ask for reinstatement within seven days of notification that their attending physician has released them to full duty. Workers who do not accept reasonable offers of employment forfeit their reemployment rights and may forfeit their wage-loss benefits as well.

The reforms eliminated medical cost growth as a cost driver after 1989.

The impact of the reforms on vocational assistance was also significant. In 1987, newly opened vocational assistance cases peaked at 9,862, representing almost one-quarter of accepted indemnity claims in the same year. Some employers and insurers say that in this period, many workers who were not seriously disabled received vocational assistance and stayed out of work longer than necessary. The much more restrictive eligibility requirement enacted later that year renders a worker eligible for vocational assistance only if he/she has a ‘substantial handicap to employment’ (that is, the worker lacks the necessary physical capacity, knowledge, skill and ability to hold suitable employment). Suitable employment includes the ability to earn a suitable wage (at least 80% of the wage paid for the employment at the time of injury or aggravation). If it is determined that a worker is capable of performing work above that threshold, he/she is not eligible for vocational assistance. As a result of the more restrictive definition of eligibility, the
number of newly opened vocational assistance cases dropped sharply to 3,258 in 1988 and continued to fall. In 1994 only 1,123 new cases were opened, just 3.6% of accepted indemnity claims that year.

Not surprisingly, opinion is divided on the impact of the drop in use of vocational assistance services. Most employers and insurers think it is positive. They point to past abuses and say that the more restrictive eligibility criteria mean that services are being provided to those who really need them, reducing disincentives for workers to return to work. Other representatives of employers and insurers are still skeptical about the effectiveness of vocational assistance. Workers’ representatives, on the other hand, argue that the restrictions on vocational assistance have gone too far. They say that the eligibility criteria exclude workers who really need the services to return to work. (WP300 p.6,10, 28, 48)

Also in 1987, the Preferred Worker Program (PWP) was introduced. It creates incentives for employers to hire workers who previously have suffered an accepted compensable injury that resulted in a permanent disability. The program has three characteristics that distinguish it from a typical second-injury fund:

- it is funded by both employers and employees;
- it is worker activated; and
- it creates direct and immediate economic incentives for employers.

Eligible workers (who are defined) are issued a preferred-worker identification card, which must be used within three years of the date of issue. When looking for new work, a worker can choose to identify him/herself as a preferred worker. The card notifies an eligible employer that by hiring this worker, the employer is entitled to receive certain benefits through the PWP, among them claim-cost reimbursement, premium exemption, wage subsidies, funds for worksite modification and other purchases necessary for the worker’s employment. The PWP limits the employer’s liability in cases where a worker suffers a new injury.

In the PWP’s first two years, 2,091 preferred workers were hired; 35% of workers issued a card in the first 18 months of the program were hired.

While generally getting good marks from those who were aware of the program, some workers did not use their card to find employment for fear of being identified as ‘damaged goods’, that is, a preferred (i.e. disabled) worker.

The Employer-at-Injury Program, which aims to lower the employer’s cost of making light-duty jobs available, was established in 1993. It offers employers direct incentives to return their injured employees to light-duty jobs while the workers are temporarily unable to return to regular work. Eligibility criteria are set down. The program is employer-activated. Several forms of assistance, such as worksite modifications and wage subsidies, are available. Although new at time of the Administrative Inventory, it was well used. It allows employers a great deal of flexibility, which
in many cases translates into a speedier return to work. It has proved particularly useful in helping insurers promote early return to work among small businesses.

Texas

Texas is another example of successful workers’ compensation reform. Two reforms are of particular interest to our research:

• the medical necessity rule tightened compensability requirements; and
• changing physicians is permitted only with approval from the insurer or the commissioner.

These reforms resulted in a $134 MM reduction in medical costs, and 25% to 50% reductions in the number of doctors involved in each case. (WP266d p.42)

Wisconsin

Wisconsin, which operates its workers’ compensation through private insurance, is considered an example of ‘a state that has been successful regulating rather than running the workers’ compensation system’. (WP266d p.26) Its success can be largely attributed to a focus on return to work. For example, in the case of permanent partial disability (PPD) benefits, which make up only 5% of claims but 54% of incurred loss, employers are motivated to offer light-duty jobs to workers at 85% of their former wage to save substantial sums on earning capacity benefits and litigation. Workers are paid low weekly PPD benefits, which gives them the financial incentive to return to work. While PPD benefits in Wisconsin have declined, so has litigation.

Washington

Washington, a state monopoly, is another state whose workers’ compensation system is widely regarded as one that works well. (WP266d, p.29) Currently a top performer, it was once in financial crisis.

Vocational rehabilitation became mandatory in 1983 for workers on time-loss for more than 120 days. This ruling had increased vocational counseling’s share of the benefit dollar from 13.7 to 48.8% by 1985. At the same time, time-loss duration had doubled to seven months for those in vocational rehabilitation programs, an indication that the benefit was no helping the worker. In 1985, mandatory vocational rehabilitation was repealed, thereby reducing benefit dollars per claim by 50%, a saving of over $400 per claim. While vocational rehabilitation is still offered where appropriate, labour agreed to the policy change because it might allow for other benefits for the injured worker. Other 1985 reforms also resulted in a decrease in time loss duration; however by 1992, the figures were still nowhere near the lows of the 1970's. The 1985 reforms also dealt with medical rehabilitation: implementation of managed care techniques and introduction of fees schedules saw medical costs decline from 20% in 1980-85 to 7.5% in 1986-90. (WP266d p.32,35) These reforms were accompanied by improved information systems for tracking and management purposes, for example, the ‘VR Electronic Link, which resulted in savings of
$360,000, and by a renewed emphasis on prevention activities. (WP266d appendix p.22) This reinforces the notion that reforms cannot be considered and/or unlikely to be successful in isolation.
APPENDIX 10

Working Papers

WP1. Rehabilitation and Compensation Services Division 1997 Business Plan

WP2. Rehabilitation and Compensation Divisions: Key Performance Indicators and Strategic objectives (1997?)

WP3. Transforming the WCB of BC: A Strategic Plan. April 4, 1996

WP4. 1995 Corporate Business Plan and Budgets


WP11. Compensation Services Division Performance Report: 3rd Q 1995
WP15. Compensation Services Division Performance Report: 3rd Q 1996


WP17. Update for Royal Commission on WCB: June 6, 1997 plus attachment:


WP20. Vocational Rehabilitation Interventions Evaluation Study. August 18, 1994


WP21 Hunt, H. Allan and Michael J. Leahy. *Vocational Rehabilitation: Policy and Practice at the WCB of British Columbia.* July 7, 1997. [How does this fit with #17?]


WP26 WCB. Rehabilitation and Compensation Services Division. Slides to accompany above presentation.

WP27 Tindall, D. *Improving the utilization of services common to BC Rehab, WCB and ICBC Project.* Draft. April 16, 1996

WP28 Comparison of Models of Diagnosis and Rehabilitation. [Source unknown, n.d.]

WP29 Rydberg Levy Inc. in partnership with the Compensation Division of the WCB of BC. *Performance Management Report for the Period Apr. ’95 - Dec. ‘96.*


WP34  WCB.  *Business Case Summary — Service Improvement Strategy.* May 26, 1997

WP35  WCB.  *Business Case Summary — Service Improvement Strategy.* April 23, 1997. [Is this a draft of WP34?]


WP43  CMA policy summary. ‘The physician’s role in helping patients return to work after an illness or injury’ in *Canadian Medical Association Journal* 1997; 156: 680A-680C.
WP44  Langille (?), Linda. Submission to the Royal Commission: E-GEN-101:  
- Legislative proposal: Child and Youth Employment Safety and Protection Act  
- Dr. Paul A. Farnan and Mary Louise O’Driscoll — letter  
- Dr. Paul A Farnan: Communications with physicians: ‘Is our employee fit for work doctor?’ slide presentation to Northern Conference on Disability Management: Developing Partnerships for rehabilitation and return to work; February 20-21, 1997.


WP47  WCB. Senior Executive Committee. Transforming the WCB of British Columbia: A Strategic Plan. April 4, 1996. [RW: note same as WP3]

WP48  WCB. Board of Governors/Panel of Administrators. Minutes (extracts) by date.

WP49  WCB. Senior Executive Committee. Minutes (extracts) by date.

WP50  WCB. SEC. Index of Submissions of Senior Executive Committee Presentations. April 4/95 - March 13/97.


WP55  Royal Commission compilation. Index of Resolutions by Board of Governors and Board of Administrators. Feb. 3/92-May 13/97.


WP58  WCB. Strategic Plan: Project Tracking. Extracts only. Feb.27/97


WP64  Royal Commission, Memo from Karen Ryan to Doug Hyatt, December 31, 1997.


WP67  Glynn/Morris, Dr. Rodney (Rehabilitation Physician) Life After Injury in New Zealand.


WP69  Texas Research and Oversight Council on WC. RTW Patterns of Injured Workers Receiving Supplemental Income Benefits.

WP70  Texas Research and Oversight Council on WC. RTW Patterns of Injured Workers Receiving Maximum Medical Improvements.


WP72  WCB Library. The Adequacy of Workers’ Compensation Benefits.

WP73  West Virginia Rehabilitation Research & Training Centre. What is Vocational Rehabilitation.


WP75  Harnden, Emond (Representing Employers in Labour Relations & Employment Law) Less Government Involvement, More Flexibility
WP76  Harnden, Emond  (Representing Employers in Labour Relations & Employment Law)  
_Emphasis on Early RTW in New WC legislation._

WP77  Benefits Quarterly.  _Why Does Workers’ Compensation Pay More for Health Care?_

WP78  Cotton, Jeremiah.  _On the Decomposition of Wage Differentials._

WP79  Blinder, Alan S.  _Wage Discrimination: Reduced Form and Structural Estimates._

WP80  Journal of Human Resources.  _On Decomposing the Wage (?)  A Critical Comment on Blinder’s Method._

WP81  Lancaster, Tony.  ‘Econometric Methods for the Duration of Unemployment’.  In:  _Econometrica_ Vol 47 No. 4.

WP82  McDonald, James B.  ‘Some Generalized Functions for the Size Distribution of Income’.  In:  _Econometrica_ Vol. 52 No. 3.


WP84  The Zenith (National Insurance Corp.)  Project.  _The Excess Costs of Health Care for Work-Related Injuries._

WP85  Phillips, Reed B.  WC Health Care Cost Containment.  _Chiropractic Costs in Workers’ Compensation._

WP86  ‘Managing Work Disability: Why First RTW is Not a measure of Success’.  In:  _Industrial and Labour Relations Review_, Vol 48 No.3 Cornell University [RW: I think we already have this elsewhere]

WP87  Gtes, Taler and Akabas.  ‘Optimizing RTW Among Newly Disabled Workers: Cost Containment’.  In _Benefits Quarterly_.

WP88  Johnson, Baldwinand John F. Burton.  _Why is Treatment of Work Related Injuries Costly?  New Evidence from California._

WP89  ‘“Movement” in Work Status After Pain Facility Treatment’.  SPINE.  Vol. 21, No. 22.

WP90  Johnson, Butler and Baldwin.  _First Spells of Work Absences Among Ontario Workers._

WP91  Thomason, T. and D. Hyatt.  _The Evolution of Workers’ Compensation Costs in Canada._


WP94 BMA. Special Forms of Assistance for Severely Disabled Persons in Working Environment.

WP95 CARF: The Rehabilitation Accreditation Commission.


WP102a Administrative inventories: What have they covered?
WP102b Administrative inventories: Is the methodology sound?
WP102c Administrative inventories: What did they say? (Summary report)
WP102d Administrative inventories: What did they say? (Detailed report)
WP102e Administrative inventories: How did the WCB respond?
WP102f Administrative inventories: Is the model appropriate?


WP103a From above: section on Compensation Services
WP103b From above: section on Medical Services
WP103c From above: section on PERU
WP103d From above: section on Psychology
WP103e From above: section on Vocational Rehabilitation
WP104 WCB. *WCB Strategic Plan: Internal and External Scan Documents.* Draft. Nov. 95.

The next 3 items are in a blue binder


The following is in a red binder: 69 items.

WP112 WCB. *BC Liberal Party - FIPPA Request of Leslie R. Peterson Rehabilitation Centre of December 16, 1994.* Table of contents notes 69 separate items which will be indexed in these WP as 112a etc.
WP112a1. Minutes of the Work Hardening Program Review of July 18, 1994

WP112b1. Memo to Extended Management Committee from Dr. Jessup about Client Input, July 27, 1994


WP112d1. Leslie R. Peterson Rehabilitation Centre Monthly Summary Report September 1994


WP112f1. Executive Committee Presentation September 7, 1994 -- Program Evaluation in the Rehab Centre

WP112g1. Senior Executive Committee Retreat September 15/16, 1993 -- Rehabilitation Centre, Program Evaluation/"Managed Care" Approach (Tab 1B)
   App A: Industrial Medicine and Managed Care: How to Survive It, S. Isernahagen, Sept. 10-11, 1993 (course outline); and Therapist Response to the Managed Care Industry, Compiled by M. Wiklund
   App B: includes a copy of WP112q1 App A: Review, Regulate, or Reform? What Works to Control Workers' Compensation Medical Costs, Workers Compensation Research Institute Research Brief, August 1994, Vol. 10, Number 8.
   App C: Discussion material, uncited.

WP112h1. Senior Executive Committee Retreat September 15/16, 1993 -- Rehabilitation Centre, Strategic and Organizational Report Committee (SORC), Interim Report

WP112i1. Executive Committee Presentation November 2, 1994 -- Program Needs Staff Survey


WP112k1. Executive Summary -- Why W.C.B. Caseloads are Unrepresentative of New Cases: An Application of Stochastic Modelling

WP112l1. Senior Executive Committee Presentation December 7, 1994 -- Rehabilitation Centre: Clients' Rights and Responsibilities
WP112m1. Executive Summary -- Ontario Medical Association Position in Support of Timely Return to Work Programs and the Role of the Primary Care Physician -- Approved as Policy of the OMA on March 23, 1994

WP112n1. Executive Summary -- Working It Out: Recommendations From a Multidisciplinary National Consensus Panel on Medical Problems in Workers' Compensation

WP112o1. Executive Summary -- Industrial Medical Council, Department of Industrial Relations, State of California, Practice Parameter, Low Back Problems
App A: Industrial Medical Council, Department of Industrial Relations, State of California, Practice Parameter, Low Back Problems (Draft 4/27/94)


WP112q1. Executive Summary -- What Works to Control Workers' Compensation on Medical Costs Review, Regulate or Reform? -- September 1994
App A: Review, Regulate, or Reform? What Works to Control Workers' Compensation Medical Costs, Workers Compensation Research Institute Research Brief, August 1994, Vol. 10, Number 8. (Also included as WP112g1 App B)

WP112r1. Provincial Rehabilitation Action Plan, Regional Framework Development Session- December 13/14, 1994 Program Outline and Attachments

WP112s1. Senior Executive Committee Presentation December 7, 1994 -- Disability Management and Prevention as Potential Solutions to Rising Health Care Costs

WP112t1. Chapter II: Demographic and Health Trends: The workforce in the Year 2000 (no citation)

WP112u1. Chapter IV: Current Trends in Disability Management (no citation)
WP112v1. Chapter V: How to Create and evaluate a Disability Management Program (no citation)

WP112w1. Chapter VI: Future Trends in Disability Management (no citation)


WP112c2. Cost-Benefit and Cost-Effectiveness Analysis for Health Promotion Programs (Patricia Z. Barry, Gordon H. DeFriese -- American Journal of Health Promotion, July/August, 1990, pp. 448-452)

WP112d2. Program Description -- The Back Evaluation and Education Program

WP112e2. Leslie R. Peterson Rehabilitation Centre Response to: "A Look at BEEP Participants 6 Months Post Discharge: Setting Standards for Program Evaluation -- May 2, 1994


WP112g2. BEEP Client Satisfaction Report (Eliot Frymire -- Program Evaluation and Research Unit -- May 30, 1994)


WP112i2. Leslie R. Peterson Rehabilitation Centre BEEP Program Utilization Report, July 26, 1994
WP112z2. Executive Committee Presentation September 7, 1994 -- RSI Early Intervention Pilot Project Update

WP112a3. Senior Executive Committee Presentation November 9, 1994 -- FEU Program Evaluation Report and Response First and Second Quarters 1994


WP112g3. Leslie R. Peterson Rehabilitation Centre Summary of Program Evaluation Findings on the Functional Evaluation Unit, Quarter 2, 1994 (Prepared by the Program Evaluation and Research Unit (PERU) October 27, 1994)


WP112i3. Executive Committee Presentation December 7, 1994 -- Hand/Amputee Program Reports


WP112l3. Leslie R. Peterson Rehabilitation Centre Program Evaluation & Research Unit Hand Unit Follow-up Questionnaire

WP112m3. An Initial Needs Assessment Survey of Amputee Clients Aged 65 and Over -- April 8, 1994 (Phil Chow -- PERU)

WP112n3. Hand Unit Feedback: A Telephone Survey of Discharged Hand Unit Workers -- September 15, 1993 (Phil Chow, Bob Prosser, Eliot Frymire -- PERU)


WP112q3. Work Conditioning Program Follow-up Survey

WP112r3. WCB Work Conditioning Program Policy/Procedures Manual (seems to be copy current as of Oct 30, 1994)


WP112u3. WCB Fellowships: A Fresh Perspective on Health Care (Heather Prime) WCB Health & Safety Newsletter -- Vol. 29, No. 3, Fall 1994


App A: Summary of Key Project Activities (chronology)
App B: Case Management: A Developmental Overview and Preliminary Results: this is WP113b
App C: Claimant Satisfaction Survey Results
App D: Stakeholder Interview Results: Angus Reid. WCB Case Management Pilot: Prince George. Oct. 97

WP113b WCB. *Case Management: A Developmental Overview and Preliminary Results.* Oct. 20/97.


WP115 WCB. *Prediction of Return to work Based on Clinical Impairment & Socio-Demographic Variables in Workers with Loss of Earnings Pensions.* Results of a pilot study 1994-95. Appendix 1: Model of Adult Disability [RW: not clear if we have a complete report or if this is only an Appendix; if so, appendix to what?]  


WP119a Weltz, A.. Email to G. Gill re: Rehabilitation Principles.

WP119b Gill, G. Email to A. Weltz re: Rehabilitation Principles.

WP120 Ison, Terence G. *Compensation Systems for Injury an Disease: The Policy Choices.* Extracts. Chapter 6: Rehabilitation.


WP125  Ontario. ‘Vocational Rehabilitation’. Bill 165 amendments.


WP128  Ernst & Young. ‘Companies require better management of disability plans.’ In: Study on Disability Plan Management ...

WP129  ILO. *Gladnet International Research Project on Job Retention/Return to Work Strategies for Disabled Workers*.


WP133  The Joint Health and Safety Committee Newsletter. *Promoting safe and early return to work*.


WP152  WCB. Practice Directives.  
(Note: there are several items; each should have its own # as in 152a)


WP157  Jessup, Barton A. Cost Containment in Rehabilitation. n.d.


WP161  Alberta Workers’ Compensation Board. Rehabilitation. (Extracts from??)


WP167  Hurley CA. Reintegration of injured workers into the workforce.


WP172  WCB. Internal Audit. Vocational Rehabilitation Committee follow-up audit. 1995 Dec 18.


WP177  WCB. Internal Audit?. Analysis of Vocational Rehabilitation Services and LOE pension awards. 1998 Jan 21.


WP180  Royal Commission on WCB, Minutes on Definitions of Rehabilitation meeting. Jan. 9, 1998


WP185  WCB, BOG Minutes: Vocational Rehabilitation Program Evaluation.  1994 Oct.  3  
[re: WP49]

[re: WP49]

WP187  WCB, SEC Minutes: Rehabilitation Centre Strategic Plan.  1995 March 8.  
[re: WP49]

WP188  WCB, SEC Minutes: Vocational Rehabilitation Evaluation Study.  1994 April __ 
[re: WP49]

WP189  Royal Commission, Ryan K. and Weltz, A.  The High Risk Project and WCB  
Research: Meeting notes with Dr. Bart Jessup.  1997 March 17.


WP196  WCB, Disability Management: Summary Outline and Background Docs.  1996.

WP196a  Short Term (Wage Loss) Claims

WP196b  Programs, Services, and Clients Treated

WP196c  Clinical Practice Guidelines: Low Back Pain


WP196f  Vocational Rehabilitation: Strategic Action Plan.  no date.

WP198 Ward, J.R.  Worker’s Compensation Managed Care.  N.C. Industrial Commission.

WP199 How to Evaluate Disability Under Wisconsin’s Worker’s Compensation Law.

WP200 Wisconsin Worker’s Compensation Guide.

WP201 Harris, K.  Defining, Measuring, & Predicting Return to Work in Florida.


WP203 Alabama: Vocational Rehabilitation Service: Community Rehabilitation Programs. 1996.


WP206 Workers Compensation: Key Points.  I.I.I, U.S.

WP207 Worker’s Compensation in California.

WP208 Return to Work for Less than 100 Weeks.  Michigan Worker’s Compensation.

WP209 Survivor’s Benefits.  Michigan Worker’s Compensation.

WP210 Facts on Workers’ Compensation and RSIs.  AFL-CIO.


WP212 Hrudey, W.P.  Over Diagnosis and Over Treatment of Low Back Pain: long term effects.


WP214 Dorsey, J.  Defining Worker’s Compensation Doctoring in the ‘90’s.  WCB BC.


WP216 Workers’ Compensation Reform: 3rd Anniversary Report.  California Dept. of Industrial Relations.
WP217  Vocational Rehabilitation Services’ Advisory Council--Terms of Reference.  1993 January 22.

WP218  Vocational Rehabilitation Committee--Terms of Reference.  1992 July 7.

WP219  Advisory Council Appointments.  no year given.


WP225  Stephen, M.  Memo to VRC’s re: Job Search Guidelines

WP226  Alley, H.  Memo to ODS Officers re: Preventative Rehab.

WP227  Weavers, G.  Memo to all Client Services Managers re: Preventative Rehab.  (Revised)

WP228  WCB, Vocational Rehabilitation Expenditures to 1996.

WP229  Master’s Program in Vocational Rehabilitation Services.  1995 December 01.


WP233  Harder, Dr. H.  Memo re: use of contractor by rehabilitation consultants.  1995 October 24.

WP234  Harder, Dr. H.  Memo re: clarification of business start-up policy.


WP239 Comparison of Workers’ Compensation Arrangements in Australian Jurisdictions. The Secretariat Heads of Workers’ Compensation Authorities. 1997 January


WP242 Occupational Health Services : A Practical Approach. Ch. 7 Worker’s Compensation.

WP243 Guidance Note for the Best Practice Rehabilitation Management of Occupational Injuries and Disease. Australia OSH Commission. 1995


WP245 Ontario Workers’ Compensation Act amendments to Bill 165: Vocational Rehabilitation. 1995

WP246 Chansky, Joel S. Keeping Workers’ Compensation Costs Under Control. 1995


WP249 Workers Compensation: Key Points. I.I.I.


WP251 Workers Compensation Board of Manitoba. Vocational Rehabilitation at the WCB of Manitoba. n.d.

RW: WP’s sorted to this point
TOR 3(C) – Wallbank Final Report – 7-Dec-98


WP254 Rathburn A and Seeman J Identifying and measuring key characteristics of disability rehabilitation candidates. Employment Relations Today 1994 Autumn


WP259 RC. Selected press clippings on return to work. From Darlene Dorion.


WP262 ACES Accelerated Case/Claims Evaluation System, Literature Review, undated. This appears to be a series of articles from journals and possibly some overheads they have created. Do you want a list like I did for FIPPA? or only if we use any of it?

WP263 Also the clinical practice guidelines doc. you sent over, does it have a number?


WP265 Wallbank, R. Notes on Angus Reid claimant satisfaction surveys.


WP266a Vol 1
WP266b Vol 2
WP266c Vol 3
WP266d Vol 4
WP266e Vol 5

WP266 f Appendix


WP270 BC. Crown Corporations Secretariat. 1997/98 estimates information

WP271 BC. Crown Corporations Secretariat. Performance reporting requirement


WP273 BC. Crown Corporations Secretariat. Enhancing accountability for performance: a framework and an implementation plan. (Extracts)


WP276 WCB. Bogyo, T. Notes on Royal Commission Day in Prince George

WP277 Sehmer, J. Interview with Dr. David Hunt. 1998 Feb. 11?

WP278 Wallbank, R. Interview with Diane Sjodin, Manulife Financial. 1998 Feb. 11.


WP280 WCB. Memoranda of agreement and fee schedules.
WP280a Medical rehabilitation program MoA
WP280b Schedule B - Medical rehabilitation program fee schedule
WP280c Worksite reintegration program — activity related soft tissue disorders MoA
WP280d Schedule B - Worksite reintegration program — activity related soft tissue disorders fee schedule
WP280e Occupational rehabilitation program MoA
WP280f Schedule B -- Occupational rehabilitation program fee schedule
WP280g Work conditioning program MoA
WP281  Schedule B Work conditioning program MoA fee schedule

WP282  WCB. Occupational rehabilitation proposal package.

WP283  WCB. Johnson, L. Presentation on ASTD’s to Commission Researchers. 1998 Jan. 30. (Slides)

WP284  Submission to RC (note: this will eventually be included in the Submissions WP list, but Nancy has that and I can’t give it a number right now - so use this for the moment) BR Psychological Association. Submission to RC. Sub. I-PAS-018


WP287  Greeley, RM. Carpal tunnel syndrome is treatable.

WP288  Oakes, MT Countering chronic pain myths.

WP289  US. Rehab Services Administration. Basic vocational rehabilitation services.

WP290  US. Rehab Services Administration. Special projects and demonstrations for providing vocational rehabilitation services to individuals with severe disabilities.

WP291  US. Rehab Services Administration. State plan for the vocational rehabilitation services program and state plan supplement for the supported employment services program.


WP293a  Benefit Software Inc. Workers’ compensation claims costs continue to plague thousands of employers. (Software advertising)

WP293b  Comp Watch. Software that gives you the power to eliminate the paperwork nightmare and reduce workers’ comp claims and costs.


WP301 Summary of Administrative Operating Expenses, 1995 to 1998, WCB.

WP302 RSCD Operating Report for YTD September, 1996 (extracts), WCB.


WP304 CSD Operating Report for YTD June, 1996 (extracts), WCB.

WP306 RSCD Operating Report for First Quarter, 1997 (extracts), WCB.

WP307 RSCD Operating Report for YTD June, 1997 (extracts), WCB.

WP308 Medical Services and X-ray 1994 Budget Presentation, WCB.

WP309 Orientation Manual for WCB Physicians, WCB, 05/96.

WP310 Clinical Practice Guidelines for the Diagnosis and Treatment of Low Back Pain, WCB, October 4, 1995.

WP311 Medical Services Department Procedure Manual for Physicians, WCB, 06/97.


WP313 Medical Advisory Committee Terms of Reference (draft), WCB, 1997.

WP314 Technology Committee Terms of Reference (draft), WCB, January 20, 1998.
WP315  Memo from Dr. Don Copley to DAMAs re: PFI Outline, January 7, 1997
WP316  Permanent Functional Impairment Outline, WCB, August, 1995
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