Association of Workers' Compensation Boards of Canada
Association des commissions des accidents du travail du Canada

Jurisdictional Update Report

Date: May, 2015

To: Compensation and Benefits Committee **From:** BC

Committee Member: David Young

Committee Mandate	
The AWCBC Compensation & Benefits Committee works collaboratively to share experiences, identify and improve claim-related outcomes, and identify and action opportunities around operational, research and policy development initiatives.	
Goals	
1. To share jurisdictional experiences and knowledge.	
2. To put before the committee, emerging issues that are deemed high priority, for consideration of planning.	
3. To identify, plan, and carry out specific projects for the benefit of the committee members and their respective jurisdictions.	
4. To be available to other AWCBC / national committees to provide input and or partner, with when requested.	
5. To provide feedback to AWCBC Executive, when required or requested.	

Objective	Activities	Target Date(s) /Status	Budget
Repetitive Strain Injuries	Repetitive strain injuries (RSI's) fall under the umbrella of ASTDs (Activity-related Soft Tissue Disorders) in BC, and total about 5200 claims per year. Somewhat unique to BC's legislation are that these claims (conditions) can be considered as either a Personal Injury (under Section 5) or as an Occupational Disease (under Section 6), depending on the exact diagnose(s). This fact often complicates the adjudicative process. Conditions that fit this criteria range from the simple tendonitis through to 'Unspecified Multiple Tissue Disorders'. Current trends related to an aging workforce also see conditions of general body deterioration being viewed as potential ASTDs (RSI's), arthritis, etc. **Best Practices:** ASTD claims are adjudicated by a specific group of Case Managers who have received training in ergonomic risk assessment. The more complex conditions are adjudicated following a worksite risk assessment performed by the Case Manager. • The advantage to this approach is that the worker and employer meet face-to-face with the Case Manager/decision maker at the worksite. An educational component aimed at risk mitigation and return to or stay-at-work benefits are discussed at that time. This leads to reduced duration, where on average over 80% of workers with ASTDs return-to-work within 26 weeks. • With a CM completed Risk Assessment on file, the information available to other staff (MAs, VRCs) is enhanced, and beneficial in the RTW and assessment of limitations/restrictions process as may occur on some claims. • The Case Manager performing the jobsite visit (JSV) also educates the employer on risk reduction and, anecdotally, WorkSafeBC sees a reduction of claims from many of the larger employers (i.e., those who are able to act on the recommendations). The less complex claims are managed through a triage desk. The focus in such cases is timely, consistent adjudication of the less complicated claims (no JSV required). This is a new process and early reviews indicate that it will be a success, providing more timely service to WorkSafeBC's customers. **Successes:** Durable adjudicative decisions result from this approach, with an 84% overall appellate (i.e., from the Review Division) uphold rate, and a 90% uphold rate when a JSV is completed. Improved customer service and quality adjudication is achieved through the Case Manager's attendance at the job site. Injury reduction/prevention is achieved where the employer works with the Case Manager to mitigate the ergonomic risk(s) in the workplace following a site assessment. **Challenges:** WorkSafeBC's challenges have been mainly around the issues of timeliness and consistency, due to the time it takes to arrange and complete a Risk Assessment.		

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	Achieving consistency in the adjudication can also be challenging. However, with a more uniform approach and oversight (as stated previously), the consistency is improving. WorkSafeBC anticipates the introduction of the triage process (for less complex adjudication desks) will improve this statistic appreciably. Challenges also exists for Case Managers who must be at the worksite while trying to manage ongoing claims. Measures are being contemplated that will improve their ability to complete both functions of their job, either through the use of initial adjudication versus ongoing claims management desks, or a transfer of claims once the initial adjudication is complete.		
Psychological Injuries	**1. MENTAL DISORDERS** Since 2012, BC's legislation (section 5.1) specifically allows for coverage for mental disorders that are predominately caused by significant work related stressors, including bullying and harassment, and mental disorders that are a reaction to one or more work related traumatic events. **A) Best Practices** • Centralized, interdisciplinary team that includes physicians, psychologists, Mental Health Specialists (social workers and clinical counselors), Case Managers, Nurse Advisors and Vocational Rehabilitation Consultants to adjudicate and case manage this claim set. Benefits of this approach include: - Enhanced quality oversight (more consistency in the decision making); - Able to focus on training a core group whose, skills and knowledge can be regularly refined to respond to changes, such as policy and appellate input; and, - Responsive to the unique needs of injured workers who have self-identified as being emotionally fragile. • Development of numerous job aids to guide evidence gathering and case management, which includes obtaining a comprehensive medical and employment history, to understand the worker's baseline functioning. **B) Challenges** • Privacy Issues • Different causation test for traumatic event(s) vs. significant stressors • High suspension rate • Difficulty obtaining timely medical documentation • Predominant cause tests requires significant investigation into the worker's personal life, and can be considered quite invasive • Very emotional client base requiring "high touch" approach • Return-to-work issues especially for bullying and harassment		

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	C) Statistical Information – 6, 718 new mental disorder claims registered (July 1, 2012 – March 31, 2015)
	
	Of Top 4 sectors for new mental disorder claims registered:
	• 1851: Health Care Sector
	• 755: Transportation
	• 590: Retail
	• 537: Accommodation, Food and Leisure
	
	Of the 6,718 claims received:
	• 1,055 claims were allowed. Of these, 96 were accepted for bullying or harassment
	• 1,863 claims were suspended *(claim could be further investigated, but has been suspended - most usually due to a lack of continued participation by the worker, and often because the worker did not want to undergo a psychological assessment, as required by the legislation, or be involved in a workplace investigation)*
	• 515 claims did not require adjudication *(no decision on whether to accept the claim was required as there was no time loss and no medical treatment was sought)*
	• 286 claims are in the process of adjudication; and
	• 2,999 claims were disallowed, typically because:
	    o The matter involved a decision of the employer, which is excluded by the legislation as a basis for coverage or
	    o There was conflict in the workplace, but it did not rise to the level of bullying or harassment or otherwise constitute a significant stressor, or the condition was not a diagnosable mental disorder
	Of the 2,999 claims disallowed, 47% involved some allegation of bullying and harassment.
	
	2. COMPENSABLE CONSEQUENCES – Psychological Conditions
	
	We have recently issued a new Practice Directive ("PD") to assist Case Managers in adjudicating psychological conditions that arise as a possible consequence of a compensable physical injury.
	
	The PD explains the meaning of 'causative significance,' and includes advice for adjudicating claims where there is evidence of a pre-existing psychological condition or multiple factors have contributed to the condition. The PD also highlights the importance of supporting return-to-work efforts for workers with psychological conditions.
	
	The PD (C3-5, Compensable Consequences – Psychological Conditions) is posted on our website:
	
	http://www.worksafebc.com/regulation_and_policy/practice_directives/compensation_practices/practice_directives/default.asp		

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	A) Mental Health Recovery Guides In 2014 we developed new recovery guides for the three most commonly accepted conditions: Depressive Disorder, Anxiety Disorder, and Post Traumatic Stress Disorder. These guides explain the optimal duration based on the Medical Disability Guidelines and make clear to the case management team that indefinite, ongoing absence from work is not expected, recommended or helpful to recovering workers. *I can make copies available upon request* **B) Treatment Provider Contracts** We view mental health treatment as the application of individually tailored, evidence-based therapeutic interventions with the primary goals of assisting injured workers to remain at or RTW, and to recover from psychological condition(s) accepted as the result of workplace injuries. In 2014 we made changes to our mental health treatment contracts to provide: • A primary focus on RTW • Treatment specific to accepted DSM-5 diagnosis • Services redefined to reflect evidence based practice • Reports and fee codes to distinguish each service type • A collaborative approach for claims management • New selection criteria for preferred providers Our treatment program for mental health includes three distinct service types, each with specific expectations, timeframes, and objectives: **1. Resiliency Support Service (RSS):** The over-arching goal of RSS is to assist workers with the development of active coping strategies and/or access to community supports and services, so that they may either remain at or return to work. No DSM-V diagnosis is required for this service. **2. Recovery and Return to Work Standard Treatment:** This is targeted individual psychotherapy provided to workers with one or more accepted psychological conditions. The over-arching goal of Standard Treatment is to assist the worker to remain at or RTW, and to promote a return to pre-injury psychological functioning. This must include the consideration of RTW factors, including a plan to address psychological recovery. **3. Supplemental Service:** Service available to workers with accepted psychological conditions who continue to experience severe psychological impairment after Maximal Clinical Recovery (MCR) is reached. The over-arching goals of Supplemental Service are to reinforce the skills the worker needs to maintain his or her maximal level of psychological functioning, to promote independent functioning by establishing links to community supports for long-term support, and to prevent significant decomposition or deterioration of psychological functioning.		

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Quality Assurance	While our line managers "own quality", WorkSafeBC has a central support Department that plays a key role in the development and implementation of operational practice and procedure on compensation matters. The Compensation Practice and Quality Department is responsible for the development of adjudicative support materials and related business procedures that foster quality decision making and enhance customer service. The Department supports claim staff and managers by providing clarity of adjudicative requirements, timely and relevant learning opportunities, and efficient claims management systems and processes. Quality initiatives are identified by listening to staff, managers, and stakeholders, conducting data and report analysis on operational performance, and providing file reviews. Some of the Department's key deliverables include adjudicative guidance documents (i.e., Practice Directives, 'Question and Answers', and Practice Alerts) that assist officers in decision making. The Quality Managers also provide training (on discreet issues), conduct quality assurance audits (on an *ad hoc* basis), and they provide a 'help desk'/feedback function to assist officers whenever they require assistance. ------------ Our corporate Internal Audit department also performs targeted claims related audits to ensure compliance with law and policy and to measure the effectiveness and efficiently of operations.		
Return to Work	In 2012/13, with the benefit of research and focus groups with staff and line managers, we launched a new initiative that identified 15 best practices in the three pillars of "planning," "relationships," and "quality service." This is known as the Three Pillars of Case Management.		

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	Three Pillars of CM - 15 Best Practices **Relationship:** Develop and maintain a relationship of trust with the worker; Complete an initial interview with the worker; Create Service Agreement for ongoing worker contact; Complete an initial interview with the employer; Create Service Agreement for ongoing employer contact **Planning:** Complete Initial Claim Review; Create a Recovery and RTW Plan; Identify and mitigate Return to Work Risk factors; Understand the Medical Recovery Guidelines; Identify and act on early intervention opportunities; Proactively manage the Recovery and RTW plan; Facilitate Team Meetings **Quality Service and Adjudication:** Provide timely and accurate decisions; Advise workers and employers of the decisions made in plain language; Be available and return phone calls 1 The role of the Case Manager is to assist the injured worker in his or her recovery, and to help them get back to work. To succeed, the Case Manager needs a recovery and return-to-work (RTW) plan. To develop and implement the plan with the worker, there needs to be a relationship of trust, and to maintain that trust, the Case Manager needs to provide good quality service. In 2013/2014, we focused on four of the 15 best practices: completing the initial worker interview, completing the initial employer interview, identifying and mitigating RTW risk factors, and proactively managing the recovery and RTW plan. In the Fall of 2014, we hosted a two-day professional development conference for case management teams around the province. The conference, "Influencing Return to Function, Life, and Work," served to re-enforce the importance of early identification and mitigation of the key contributors to prolonged duration, chronic pain, and the development of mental health disorders as a consequence of injury. While these are our most complex claims, our goals remain the same - to improve return-to-work and the service experience for workers and employers. Since teamwork is vital to improving RTW outcomes and delivering customer service excellence, the session joined Case Managers, Vocational Rehabilitation Consultants, Medical Advisors, and Psychology Advisors. Bringing together the entire case management team was intended to provide a real opportunity for collaboration, as we shared new material and best practices.		

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	Our agenda from the conference:		

Session Topic	Key Messages
Disability: What is it?	• World Health Organization definition • Medically necessary vs unnecessary disability • What influences disability? • Our role in influencing/preventing disability
Preventing Needless Disability: Return to Work/Return to Life	• Biomedical v Biopsychosocial model of disability • The role of work in health & well being • Changing trends in the workplace • Disability duration: Physician role • International Classification of Disability Model
Recovery/RTW Screening Questions	• What are RTW factors? How do they influence • Identify Green, Yellow and Red RTW factors • Documentation of Sensitive Claim information
Influential Interviewing	• Identify worker's response to injury and approach to recovery • Setting/Influencing expectations • Responsibility for recovery...action plan • Coping with communication challenges • Influencing attitude and behavioural change
Mitigating RTW Factors	• Urgency…the need for early identification & intervention • Meaning & importance of common RTW factors • Mitigation strategies
Health & Wellness	• Maintaining resiliency and health in the Case Mgmt team
Working with the Team	• Team meetings: mandatory/recommended • Preparation for team meetings • Purpose, intent and goals of team meeting
Psychological Conditions as Compensable Consequences	• Introduce interim Practice Directive • Causative Significance - what does it mean? • Evidence-based decision making • Pre-Existing Psychological Conditions

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	MD Guidelines	• How to use MDG disability guidelines • Understanding Risk, Capacity, Tolerance for RTW		
	Mental Health Recovery Guides	• Understand the nature of the top three mental health disorders- Depression, Anxiety, PTSD • Focus on RTW- the therapeutic role of work in mental health recovery • Difficult conversations: dealing with clients with mental health disorders		
	Restrictions and Limitations	• Identify medical restrictions and functional limits • Changing the focus from disability to ability • Psychological limitations and RTW planning		
Non Diagnostic Conditions	The adjudication of 'chronic pain' (subjective complaints of pain in the absence of any objective findings) is a challenge. Certain medical conditions are considered to be synonymous with chronic pain (Fibromyalgia, Myofascial pain, Non-specific pain, and Headaches (not migraines)). Best practice with these types of conditions would be early identification of the issue, mitigating risk factors, activation, early RTW, normalization and reassurance. In 2014, we rolled-out refresher training to our Case Managers on chronic pain. Our objective was to promote quality adjudication and reinforce effective stay at work / RTW options. **Key messages:** **The Management of Chronic Pain - Determining the appropriate treatment plan** • DO normalize / DON'T medicalize • DO consider a referral to a Community OT to support the worker in returning to "normal activities" • DON'T automatically refer to an OR1 or OR2 for clinic based treatment • DO consider that a clinic based program may add 6 weeks of duration • DO make an early referral to Pain Management Program if indicated • DO recognize the value of a supernumerary RTW or a return to modified duties **Working with the Medical Advisor** • When and why to refer to the MA • How to ask properly worded MEDICAL (versus adjudicative) questions • What not to ask the MA • How to work with the MA to ensure only genuinely necessary treatment/investigation is approved			

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	How to Properly Adjudicate
	• Is chronic pain a compensable consequence?
	• Is the chronic pain a temporary condition?
	    o If so, accept on a temporary basis, monitor the worker's recovery and anticipate the condition will resolve completely
	• Is the chronic pain only a permanent condition?
	    o If so, accept and refer to Disability Awards – mostly status quo
	• Is there evidence of chronic pain in addition to another permanent condition?
	    o If so, accept both conditions as permanent and refer to Disability Awards
	• When is a worker at plateau and what decisions flow from that?
	• How can we accept permanent chronic pain with no restrictions and/or limitations?
	• Chronic pain versus pain disorder/Somatoform Symptom Disorder (DSM 5)
	
	Attached is our revised Practice Directive		

KPI's	• STD Timeliness: 18.9 days (*date of disablement to first pay*) • RTW at 26 weeks: 80% • Active Claims Inventory: 1,102 STD claims >240 days • Voc Rehab RTW Outcomes: 81% • Employers' Overall Experience: 82% good/very good • Injured Workers' Overall Experience: 75% good/very good *See attachment*		