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

Jurisdictional Update Report

Date: April 2015

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

Committee Member: Dan Holland

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		
Repetitive Strain injuries	• We rely heavily on the use of outcome measures when trying to manage recovery and RTW involving injuries such as tendinitis, etc. The focus is on function. Physiotherapists tend to provide better information and regularly utilize outcome measures as part of their practice. • Medical evidence suggests that repetition alone is not sufficient to cause these types of injuries. As part of our criteria, we look for both repetition and the application of force. For example, prior to accepting a claim for CTS, we would look for job duties involving forceful/repetitive grasping. • Our Medical Advisors make the point that there is a tendency in the community to use the term RSI as a diagnosis. They try to avoid using the term in this fashion as it is simply a mechanism of injury not a diagnosis unto itself.		
Psychological Injuries	• The WCB has been asked by the Government of Manitoba to seek views on workers compensation coverage for Post-Traumatic Stress Disorder (PTSD) through a public consultation process. Specifically, presumptive legislation is being considered for first responders. We anticipate this going through. I understand Alberta has similar legislation in place and would be interested in their experience in terms of any changes in PTSD claims volume, etc. • Psychological injuries, in general, have been a challenge for our Board. Treatment providers tend to treat without evidence of significant improvement in function or symptoms. We currently do not have any formal agreement with psychologists in Manitoba. We also do not have standardized reports. Employers are frustrated relative to trying to accommodate RTWs along with claim costs. • We have two PHD psychologists and two psychiatrists with our Healthcare Services department. They offer opinions on causation and treatment options to our Case Management staff. They also will interview injured workers and offer opinions on diagnosis. We also have a Pain Management Unit consisting of one GP and one psychologist who see workers whose issues seem to be overwhelmingly pain related. They will ensure that all physical issues have properly been addressed and offer opinions and treatment options on pain management. They also are heavily involved in the review of files dealing with opioid use and associated addictions.		

Objective	Activities		
	• We often find that many workers have non compensable psych conditions that impact on recovery. At the point of claim closure, we offer workers ongoing counselling/treatment through our Transitional Services program. It essentially provides for a limited number of sessions for individuals who have ongoing issues but have limited resources. Financial counseling is another service that is offered by an external provider free of charge to the worker if their claim is denied or upon closure. We have negotiated contracts with the third party providers. Costs are not billed to the claim file. • A challenge we face is the fact that we do not use preferred providers and due to the fact that treatment by psychologists is not covered by Manitoba Health, psychologists have a natural self interest in extending treatment and are not focused on RTW when costs are covered by TP insurers. Narrative reports are often repetitive and not overly helpful. Aggregate yearly costs have not been too bad historically but they are trending upwards.		
Quality Assurance	• We are currently in the middle of a divisional restructuring. A new area is being developed called Compensation Performance, Training & Quality. Part of their responsibility will be to develop performance standards for the various roles within Compensation Services, to develop associated KPI reporting and to offer audit services. We have developed best practices for Case Managers and formal training will take place in Q4 this year. The best practices will form the basis for our quality audits. Exact format and frequency of our quality reviews has yet to be determined.		

Objective	Activities		
Return to Work	• We are developing a new area called Employer Relationship Management. The manager for the area has been hired and additional staff will come on board in the next few months. As part of their mandate, they will be identifying employers who have substandard (or nonexistent) disability management programs. Once identifying follow up will occur with the offer of support in the way of RTW consulting services. Staff in the area will carry out audits, identify gaps and offer recommendations and support to these employers. In addition, employers will be offered training in the way of two regularly run WCB courses (WCB Basics and RTW Basics). • The WCB of Manitoba has legislation that requires employers with greater than 25 employers to offer suitable accommodation to injured workers who have been employed for at least 12 continuous months. The obligation to re-employ is required to the point of undue hardship and failure to comply could result in an administrative penalty (to an amount not exceeding the worker's average earnings for the year prior to the injury). • As previously mentioned, we have developed best practices for Case Managers and RTW processes are included. I've attached a copy of the best practices for your reference. All CMs will be going through formal training on them later this year. • WCB Healthcare Services department have adopted the concept of risk, capacity and tolerance when providing opinions on RTW. Risk relating to the likelihood of aggravation or enhancement of the injury/condition. Capacity referring to the individual's physical ability to perform their work duties. Finally, tolerance is the worker's subjective report regarding how long/how much they can do. • Our Communications department is developing a media campaign directed at the general public as well as healthcare professionals with respect to the benefits of RTW. We hope to change attitudes and ultimately behaviours with respect to RTW.		
Non Diagnostic Conditions	• Concussion and post concussion syndrome - This is an area of increased media coverage and general awareness in the community. We have seen a dramatic increase in the number of reported concussions and reported symptoms of post concussion syndrome (which is even more nebulous). Our Healthcare Department developed a position statement on concussions and post concussion syndrome to assist with the adjudication process. A copy is attached. We were finding that many individuals were being diagnosed with post concussive		

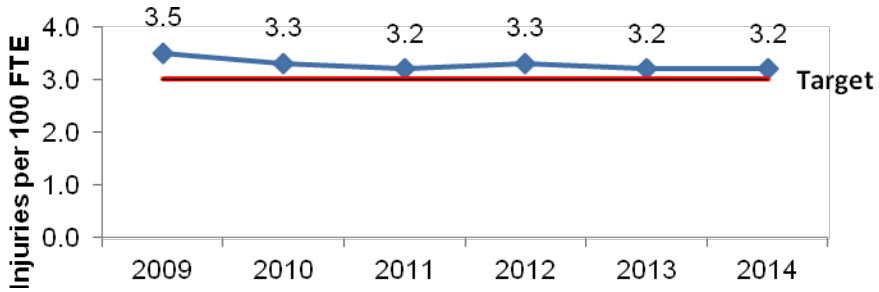
Objective	Activities

syndrome weeks after the injury often without ever having any significant head trauma. Due to reported symptoms, their physicians simply offer, in the absence of an intervening event, that they must be related to the injury. This position statement has helped somewhat in getting in front of these cases. However, once the diagnosis is accepted, we are still challenged with finding appropriate treatment and facilitating early RTW. Many healthcare professionals are recommending total brain rest and not return to any activity until all symptoms have abated which is not evidence based.

KPI's

Claim Duration						
2009	**2010**	**2011**	**2012**	**2013**	**2014**	**Target**
41.0	37.4	34.8	34.0	32.7	31.0	34 days

Time Loss Injury Rate[i]



Accepted Timeloss (TL) / No Timeloss (NTL) Injuries - YTD

Objective	Activities

	2009		2010		2011		2012		2013		2014	
	TL	NTL	TL	NTL	TL	NTL	TL	NTL	TL	NTL	TL	NTL
Agriculture	284	242	260	246	268	214	279	218	229	188	233	246
Construction	1,940	2,106	1,844	2,135	2,035	2,304	2,063	2,206	2,017	2,161	1,934	1,964
Healthcare	2,613	2,092	2,715	2,128	2,463	2,079	2,532	2,069	2,503	1,856	2,420	1,915
Manufacturing	3,020	3,653	2,630	3,246	2,855	3,588	2,721	3,435	2,557	3,029	2,469	2,857
Other Service	1,891	2,041	1,854	1,877	1,762	1,982	1,821	1,933	1,983	1,859	1,847	2,034
Self-Insured	1,760	1,720	1,830	1,897	1,969	1,957	1,938	1,742	1,957	1,700	1,882	1,872
Trade	2,367	2,477	2,357	2,466	2,174	2,540	2,170	2,344	2,161	2,122	2,169	2,234
Transportation	1,271	979	1,190	996	1,183	982	1,168	937	1,205	963	955	1,147
All Other	362	912	359	941	435	917	444	998	367	920	469	933
Total	**15,508**	**16,222**	**15,039**	**15,932**	**15,144**	**16,563**	**15,136**	**15,882**	**14,979**	**14,798**	**14,570**	**15,010**

Claims Costs Incurred ($ 000s)						
2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2014 Budget**
198,807	182,135	195,235	216,021	268,255	222,100	268,605

Assessments							
	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2014 Budget**
Premium Revenue ($ millions)	217	228	228	240	246	254	255
Assessable payroll ($ millions)	13,394	13,946	14,726	15,595	16,288	16,894	16,916
Average Rate ($, per $100 of payroll)	1.59	1.61	1.51	1.51	1.50	1.50	1.50

Objective	Activities		
Additional Information / Items			