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

Jurisdictional Update Report

Date: May 15, 2015

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

Committee Member: Jeff Pare

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	**Key details for an Eligibility Adjudicator to consider:** **Repetition** –frequency, speed and duration of repetitive task **Posture** – neutral, awkward, duration of static postures **Force** –what is the force required to perform the task and the duration the force is exerted before a break Other factors include: • Workstation design-inappropriate work surface heights, excessive reaching • Equipment and Tools-hard to reach controls, awkward grip ,force required to use tools • Environment • Work Practices – large volume(piecework) , inadequate breaks or task variation, lack of control by individual over speed of work **Case Management:** The WSIB has Programs available to assist Case Managers in helping workers with RSI injuries: **Musculoskeletal Program of Care** (MSK POC) Background: The new MSK POC is similar to our other POC's. It provides evidence-based health care interventions for workers with musculoskeletal injuries. The focus of the program is on achieving the best functional outcomes and return to work. Contributions to the MSK POC were made by the Ontario Chiropractic Association, Ontario Physiotherapy Association, Ontario Society of Occupational Therapists and the Registered Massage Therapists' Association of Ontario. The 4 health professional associations that contributed to the model are aware and understand the provider accountability in achieving good functional and return to work outcomes. The new MSK POC commenced June 2, 2014 so we are just coming up to a year. Key Principles: • Health care programs focus on functional recovery • Work is important to overall well-being & beneficial to recovery • Early re-activation speeds up healing • Return to work enhances recovery and is part of the rehabilitation process • Gradual resumption of work tasks lessens fear & anxiety • Reporting requirements and includes an outcome summary prior to payment		

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	POC's In General: • Enable early, safe and sustained return to work • Assist workers to return to pre-injury level of overall function and quality of life • Achieve satisfaction with the quality of care among workers and employers • Prevent chronicity • Each has timeframes to be eligible for the program from DOI (e.g. With an acute low back injury can enter up to 6 weeks from the date of injury/recurrence) • Who may also have another injury that does not preclude the worker from participating in this POC • To be eligible the worker must not have any clinical evidence of red flags • Still at work (modified duties) or off work • Not hospitalized • A key element of the POC is communication with various parties: • Communication with the worker should include education to help them in understanding their injury, expectations setting, allaying any fears or anxiety and providing positive messages regarding recovery and return to work. Education should also involve descriptions of home exercise programs, including teaching the worker self-monitoring of activities which will promote them to challenge and improve their function, while avoiding re-injury. These messages are very important to the success of any treatment plan. • WSIB offers a Clinical Expert POC telephone line which is covered by health professionals with active practices who will assist the service provider with any clinical questions they may have. • The WSIB also does auditing and evaluating the providers of our POC programs to ensure recommended interventions are provided and outcomes are *achieved* as expected. • Outcome measurement is required at admission and discharge: The type of measurement varies with the POC involved. Example for LBPOC use --Numeric Pain Rating Scale and Roland-Morris Disability Questionnaire. For MSK use Patient Specific Functional scale Other key outcome reporting include: • Clinical findings • Return to work recommendations including functional abilities • Summary of care delivered **Upper Extremity Hand and Wrist Program** provides assessment and treatment services to achieve early and safe return to work for workers with hand and or wrist injuries that are complex in nature. A Comprehensive Interdisciplinary Assessment involves orthopaedic surgeons,		

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	hand/plastic surgeons and other health professionals. Access to a range of diagnostic tests, CT scans and electromyography are available as needed. Also available as needed are follow up assessment, reassessment, psychological assessment and specialty consultation assessment. As with all Specialty Clinics, elements of this assessment include: • Diagnosis and prognosis • Pharmacological review and screening • Treatment recommendations • Arrangements for diagnostic testing and/or consultations • Return to work recommendations • Identification of barriers to return to work • Strategies to facilitate return to work • A proposed individualized treatment plan with time frames , goals and expected outcomes Other services available in the program include: • Keyboard Assessment-conducted by an occupational therapist or physiotherapist , includes a musculoskeletal assessment, a workstation evaluation at the clinic; recommendations for modifications and additional equipment or equipment changes ; and, recommendations for additional worker training if required • Keyboard Training includes a stretching and strengthening program, stability exercises for proximal and distal control of the upper extremity and education regarding the optimal workstation setup, posture, positioning and self-management • Dominance Transfer Assessment and Training **Permanent Impairment Rating:** see attached Adjudicative Advice Document		

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Psychological Injuries	**Psychological Injuries** The WSIB has a policy on Psychotraumatic Disability (15-04-02 in the Operational Policy Manual), as well as a policy on Chronic Pain Disability (15-04-03 in the Operational Policy Manual). Under the Psych policy, to consider allowance, the psych condition has to have manifest within 5 years of the accident or the most recent surgical procedure, and one of three claims criterion needs to be met (before accepting any medical opinion on work-relatedness). The policy sets out that Psych is allowed on a temporary basis, and under exceptional circumstances, can be allowed as a permanent condition. Before the file is referred to the Psych/CPD Specialty Team to determine entitlement, it is the responsibility of the STCM or LTCM to look for "flags" in the file for emerging signs of psych or CPD. The STCM or LTCM can authorize initial treatment/refer the worker to a Specialty Clinic Program based on best practices. Early recognition and authorized treatment of non-organic conditions supports the WSIB's "Better at Work" approach. The authorization of initial treatment by the STCM or LTCM **is not** an allowance decision – only the Specialty Team Psych/CPD CM makes the allowance decision. To assist in the determination of allowance or further possible treatment, the STCM or LTCM asks the worker to have the family physician provide the WSIB with chart notes and clinical notes for the 5 year period preceding the injury. This information is then used by the Specialty Team Psych/CPD CM to compare the work-related condition with all non-work-related conditions or factors. **The focus of the Psych/CPD CM is to compensate for work-relatedness only, particularly when the file shows that the worker has pre-existing and co-morbid (co-existing) conditions.** In some cases, the Psych/CPD CM may refer the worker to one of two contracted clinics, the Centre for Addiction and Mental Health (CAMH) into Toronto, and a similar center in London, Ontario, to have a comprehensive psych assessment conducted. While these two Clinics assess the worker holistically, they understand the WSIB's focus of compensating for work-relatedness as well as returning the worker to work. It is important to note that prior to assessing the worker, these two Specialty Clinics are sent all WSIB claim file medical information, including the pre-injury chart notes and clinical notes, as well as all memos written by the Specialty Team Psych/CPD CM. These Specialty Clinics, while under a contract for service to the WSIB, are seen by WSIB stakeholders as independent from the WSIB. This perception of independence from the WSIB is valued by the WSIB, particularly in those cases where the worker's own psychologist/psychiatrist is sending the WSIB reports based on the worker's self-reporting to that professional. When allowing psych on a temporary basis, the Psych/CPD CM approves the duration of treatment plans (based on the recommendations of		

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	psychologists/psychiatrists) and determines the worker's psychological level of impairment and functional abilities (i.e., psychological restrictions or precautions/limitations). The determination of the worker's psychological level of impairment and functional abilities is used in turn by the STCM or LTCM to plan RTW and Work Transition Activities (WT). As an example, a worker who loses a finger due to an industrial accident may have a diagnosis of Post-Traumatic Stress Disorder. As a result of the worker's PTSD, that worker may have a temporary restriction of working on the machinery which caused the accident. That restriction will be used to plan ongoing RTW/WT activities. Depending on the facts of the case, a worker who has been granted temporary entitlement to psych, may need to limit their participation to treatment only, and have RTW/WT activities set aside for a period of time. Alternatively, a worker may participate in treatment while concurrently participating in RTW/WT activities. In some cases, the worker may have a non-compensable condition which delays, impedes, or prevents recovery from the compensable condition. Under WSIB policy, 17-03-04, Health Care for Non-Work-Related Conditions, the WSIB may pay for that health care, while making it clear to the worker that the WSIB is not accepting entitlement for that condition. For example, a worker who has temporary entitlement to psych based on a diagnosis of Major Depressive Disorder, may also have a substance abuse condition that has not been accepted as part of the entitlement of the claim. The Psych/CPD Specialty CM could rule that to reduce the impacts of the compensable psych condition, it is necessary and appropriate to allow for treatment of the non-compensable substance abuse condition. Based on the facts of the case, the Psych/CPD CM may subsequently determine that psych condition is considered permanent. At that decision point, the Psych/CPD CM will again comment on the worker's psychological level of impairment and functional abilities. At the same time as the file is returned to the STCM or LTCM for ongoing case management, the file is referred to the WSIB's Permanent Impairment Program to determine a Non-Economic Loss (NEL) award. In awarding a NEL, the Permanent Impairment Program may offset any pre-existing and co-existing conditions. It is rare for a worker to be considered totally impaired psychologically and unable to participate in RTW/WT activities. Under the CPD policy, all five of the claims criterion has to be met to consider allowance. If CPD is allowed, any organic NEL that was previously allowed is replaced by the CPD NEL. Similar to Psych decisions, when allowing CPD, the Specialty Team Psych/CPD CM will comment on the worker's level of impairment from a chronic pain perspective, and will comment on the limitations and precautions associated with the CPD. Determining precautions for "non-physical" injuries is challenging. The degree of pain or psychological manifestations may affect the worker's behaviour, motivation and ability to participate fully in a return to work plan. The WSIB developed a Best Approaches Guide (attached) to assist staff in managing these cases		

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Quality Assurance What is the QA framework/process within your jurisdiction? 1. Team and Functions 2. Best Practices 3. Audit	**What is the framework?** • Our quality framework dimensions are reflective of Total Quality Management (TQM) principles • This continuous improvement model allows us to deliver high-quality programs and services linked to our metrics and driven by the Strategic Plan • TQM is built on a cross-functional model of knowledge/information sharing and analysis that requires: a. **PARTICIPATIVE MANAGEMENT:** Management has a direct responsibility for quality improvement b. **CONTINUOUS IMPROVEMENT:** Incremental changes lead to larger gains c. **BUSINESS KNOWLEDGEABLE STAFF: Audit team and managers conduct reviews** • The Quality Model is a quality assurance program founded upon a set of six quality dimensions which establish a common framework and congruency for quality • The defined dimensions assist in establishing a consistent and known quality paradigm and quality framework for business reviews, training program design, content development, coaching of staff and measurement of providers • 6 dimensions- Accuracy :The right decision ; Completeness – the right information; Decision Management – the right way (i.e. within designed frameworks); Timeliness; Customer Service and communication (verbal, interpersonal, written) ; Compliance with contract (for providers) 1. There are designated Audit teams who review cases. Managers also review cases and phone interactions using a standardized framework. 2. Best Practices • Using experienced claims staff as reviewers • Managers conduct reviews at key case decision points • Accountability model for management to own the results and outcomes • Standard framework for reviews • Automated tools • Calibrating the business on the quality standards • Standardized coaching model that managers have been trained on 3. In addition to the audit of decision makers, we audit the staff who audit cases.		

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Return to Work 1. What is the return to work process for your jurisdiction	**RETURN TO WORK PROCESS** • Return to work process begins on the date of injury where an employer has a formal or informal Disability Management Program • At any time when initial entitlement is still pending, the WSIB Eligibility Adjudicator (EA) might identify barriers to RTW or a workplace dispute concerning an offer of suitable work. The EA will refer the case to a Case Manager (CM) to help facilitate the RTW or resolve barriers while the eligibility decision making process continues • The CM begins RTW planning at the initial contact and continues throughout service – CM leads RTW negotiations and sets collaborative goals with the workplace parties • Where RTW obstacles are identified and where assistance is needed, CM positions case for RTW Services referral. The case can be referred directly to one of two RTW resources **RTW Resources at the WSIB** • 100 RTW Specialists (RTWS) facilitate return to work in the workplace where the worker and employer are experiencing difficulty setting up a RTW plan or the plan is not progressing as expected • RTWS monitor RTW plans and where extensive monitoring or additional assessments and/or services are required, they can also refer directly to a Work Transition Specialist • 200 professionally designated Work Transition Specialists (WTS) support complex, longer duration claims and bring a strong background in vocational rehabilitation to help facilitate RTW primarily with the injury employer **Caseload Activity** • Return to Work Specialists (RTWS) – 17,500 referrals to RTWS in 2014, down from 21,000 in 2013. • Work Transition Specialists (WTS) – 4,360 referrals to WTS in 2014, up from 3,960 in 2013. • Worksite Visits – approximately 25,065 worksite visits in 2014 (RTWS meetings + WTS proxy 2.3 visits/referral). In 2013, there were 26,000 worksite visits.	January 1, 2015 YTD 2014 Q1, 2014	
2. Best Practices	**BEST PRACTICES** **Return to Work (RTW) Services Initiative** We have continued to improve the timeliness and quality of our RTW services through our RTW initiative that was trialed for 6 months in two offices in 2014 and then fully implemented in Q4 province-wide. The rollout of the initiative was delivered to multi-disciplinary groups to enhance understanding of each other's role and to promote the importance of communication and collaboration. (see attached document)	Fall 2014-ongoing	

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	Key focus areas include:: • CM taking the lead in collecting pre-injury job details and RTW negotiations • Critical case assessment at each touch point to determine which RTW resource is required and when; less emphasis on time-driven referrals CM positioning of referrals • Understanding of RTWS and WTS roles (both internally and externally) • Collaboration between field roles - RTWS identifying cases requiring WT services, positioning the workplace parties for WT services and setting up the WTS at the conclusion of RTWS involvement (passing on intelligence about the workplace and workplace parties at the time of handoff) • Continuous RTW services from CM to RTWS to WTS Quality claim audits are being conducted 3 months post-rollout to evaluate the initiative in combination with outcome measures. **Interim Plan in Work Transition** Given the earlier referrals to Work Transition, an approach was introduced for interim plans where: • A full recovery is expected or permanent impairment not yet known • Negotiation of RTW with IE is still in progress • Worker still in active treatment, functional abilities will improve • Potential for RTW with employer but employer unable to provide suitable work • Surgery expected but no date, employer unable to provide suitable work • Short term in nature initially up to three months to complement concurrent treatment This plan promotes recovery through activity for cases where the opportunity for recovery in the workplace does not is not available. Interim Plan activities may include: • Second language training, literacy/essential skills, academic upgrading • Short term vocational training such as computer training • Job Search Training **Employment Readiness: Motivational Interviewing Techniques** WSIB has developed a training program for all Service Delivery roles: CM, RTWS and WTS, to help identify immediately when a worker is “stuck” and hesitant about	Q1-Q2 2015	

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3. What are the successes/challenges	their ability to RTW, and by using motivational interviewing tools and techniques and "change talk", to help workers move to a state of readiness to RTW. The one-day training program is delivered to all roles together to further enhance collaboration and case conferencing, and ensure consistent messaging to workers. The program is expected to help duration by getting "unmotivated" workers to feel ready to get back to work sooner and then to stay at work. Early results from three trial launch teams are positive. Provincial roll out of the program is expected to be finished in May 2015. Post-training support being offered to Managers to ensure uptake of training by all roles. Evaluation will be completed later in 2015. **Key findings from the RTW Services Initiative quality audits include** • CM efforts in RTW negotiations has increased • Greater collaboration and understanding of roles – cases are being referred to the right RTW resource at the right time • Improvement in positioning conversations by Case Manager with the workplace parties when making a referral for RTW services and by the RTWS when referring to the WTS **Ongoing opportunities identified through the quality audits include:** • Improve communication between all roles; communication and collaboration overarches entire framework • Continue to align the two RTW roles to ensure seamless customer experience particularly with the workplace meetings • Increase case conferencing with a multi-disciplinary approach • RTW Services model needs to be customized for specialized services (Occupational Disease, Traumatic Mental Stress, and Serious Injuries) **RTWS and WT Outcomes** • Increased RTW outcomes achieved earlier and across all roles; customer satisfaction scores from both worker and employer surveys has seen improvement • Cases off full loss of earnings benefits one-month post RTWS intervention has improved from 85% in 2013 to 88% in 2014 and 90% Q1 2015 • 65% of the referrals to WTS are coming from the CM and 35% now coming direct from the RTWS; the time to WTS referral is now 6 months from date of injury or recurrence when coming from the CM and 4 months when coming from the RTWS • Percentage of WT plans completed resulting in RTW has improved from 64% in 2013 to 78% in 2014 and 79% Q1 2015		

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Non Diagnostic Conditions Background Challenges/Approach	**CRPS** CRPS is a chronic pain condition most often affecting one of the limbs usually after trauma or an injury to that limb. There are two similar forms, CRPS -1 and CRPS -2. CRPS -2 is the term used for individuals with confirmed nerve injuries; CRPS – 1 is the terms for individuals without confirmed nerve injury. The literature suggests that the vast majority of people who are diagnosed have the CRPS – 1 form. Although WSIB policy is silent with respect to CRPS, the WSIB adjudicates CRPS as an organic condition and **does not** adjudicate it under the CPD policy. Accordingly, if a diagnosis of CRPS has been confirmed, it is the WSIB Short-Term or Long-Term Case Manager who is to determine entitlement, as opposed to a Psych/CPD Specialty Team Case Manager. The WSIB is aware that the medical literature regarding CRPS is evolving regarding its two forms, as well as the significance of physical and psycho-social factors. Non-economic assessment for a permanent impairment – as there is no rating for CRPS in the AMA guide, 4 options have been developed to date these cases base on analogous body parts: • Range of Motion • If the entire limb is affected for the lower extremity use lumbosacral plexus table • Analogous to a spinal cord injury if there is an impaired gait, or • Analogous to an amputation Because CRPS is treated as an organic condition, an injured worker who has entitlement for CRPS, could subsequently claim entitlement to either Psych or CPD. If a Psych/CPD Specialty CM allows psych as a permanent impairment, a Psych NEL could be stacked on the CRPS NEL. On the other hand, if a Psych/CPD Specialty CM allows CPD, the CPD NEL would replace the CRPS NEL. The Workplace Safety and Insurance Tribunal has a discussion paper on CRPS (attached)		

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KPI's –Q1 2015 **Eligibility**	Percentage of Claims e-Adjudicated – 45% Percentage of eligibility decisions made within 10 days from claims registration-92%		
Duration (excludes Serious injury and occ. Disease)	Percentage of claims on benefits at Duration of; 3 months 9.92% 6 months 5.08% 1 year 3.11% 2 years 2.11% 3 years 1.59% 4 years 1.82% 5 years 2.66% 6 years 3.55%		
Permanent Impairment	Percentage of Lost Time Cases with PI (3 year lag) 6% Average PI award 10%		
Return to Work	RTW rate following RTW specialist last intervention -90% Percentage of RTW with injury employer following Work Transition Specialist intervention (referred within 2 yrs. from date of injury) - 62% Percentage of completed Work Transition plans employed -72%		
Service Excellence(Q4 2014)	Customer Service-Workers 77% Customer Service – Employers -89%		
Additional Information / Items			