The role of healthcare providers in the workers' compensation system and RTW – the challenge of complex conditions

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Study overview

Two year study, in four provinces, examining the role of healthcare providers (HCPs) in workers' compensation systems and RTW after injury

Funded by the Workers' Compensation Board of Manitoba

The study sought to address three broad questions:

1. What is the role of HCPs in the workers' compensation system and in the RTW process?
2. What challenges do HCPs face?
3. What can help engage HCPs in the workers' compensation and RTW process?

Study methodology

The study consisted of three parts:

1. A document analysis of materials developed for HCPs about their role in RTW and in the compensation process
2. Interviews with HCPs examining their experiences with the WC system and RTW of compensation patients
3. Interviews with case managers (CMs) about how they interact with HCPs and view their role in RTW (Manitoba and BC)

Resource scan

Goal of the document analysis:

- Identify resources created for physicians (General Practitioners, Specialists, etc) about their role in RTW and in the compensation system more broadly
  - Resources: pamphlets, websites, workshops, guidelines
- Focus on physicians - typically the primary treating clinician during WC claims
- What are physicians being told about RTW? What are the key messages about their role? Are there gaps or contradictions?
- Searched for resources in each Canadian province and territory
- Key sources: WCBs; relevant provincial or federal government ministries or agencies; medical regulatory and oversight bodies; post-secondary institutions providing medical training; union and worker organizations; community and non-governmental organizations

Caveats!

- Focus on directed not general resources
  - e.g. Information on the “HCP section” of the WCB website, not information on the website in general
- Grey literature – a constantly shifting landscape
  - materials constantly added, modified, moved, removed
- Missed materials – found references to workshops or programs but not able to locate further information; no access to certain content
- No resources included after October 2014
- 187 resources identified that met our search criteria

Resource scan – a snapshot of key findings

- Materials encourage physicians to support RTW – but details regarding mechanisms are often lacking

e.g. Contact with employer – Who? When? How often? What info?

e.g. Use of vague language – "early" RTW, "prompt" reporting

- Focus on *RTW* but not *staying at work*. Little focus on problems the physician may encounter while treating IWs and dealing with the compensation system or during the RTW process

"*Physicians should always assume that employers can and will accommodate, even if workers think otherwise*" (Saskatchewan)

- Limited guidance on "invisible" or complex conditions (chronic pain or episodic disability)
- Mental health issues typically discussed (only) as "red flags"
- Resources tend not to provide physicians with "the big picture" of how compensation systems operate

Study methodology - Interviews

- 131 interviews conducted with HCPs and CMs
- Of the 97 HCPs interviewed, 34% (n=33) were from Ontario, 29% (n=28) from British Columbia, 21% (n=20) from Manitoba, and 16% (n=16) from Newfoundland/Labrador.
- High and low volume of WC patients – at least one in the last year
- Almost half of the HCPs had over 15 years of tenure, 20% were in practice less than 5 years
- Many participants had more than one role/worked in different settings (currently or in the past)
  - Diverse group - different levels of experience with WC and RTW
- Of the 34 CMs, none were from Newfoundland and those from Ontario were employed by private organizations (some former WCB)

Type and number of healthcare providers and case managers

Type of healthcare providers	Number
Total*	***131***
General practitioners (Internal HCPs to WC boards, family doctors, walk-in clinic practitioners)	59
Allied healthcare providers (Occupational therapists, physiotherapists, chiropractor, psychologists, registered nurses)	19
Specialists (Surgeons, physiatrists, anaesthesiologists, oncologists, practitioners working in occupational health and safety, rehabilitation, industrial and sports medicine)	19
Case Managers *(*Short/long term claims, mental health, vocational rehabilitation)	34

*Some participants had more than one role.

Procedure and Analysis

- HCPs recruited through professional networks, medical associations, message boards, social media, WCBs (BC/MB only)
- Interviews conducted in person or telephone, recorded and transcribed
- Transcripts entered into Nvivo (qualitative data analysis software) for data storage and organization
- Transcripts reviewed by researchers and code list developed
- Data coded, then organized thematically – inductive approach, but with an aim to address key research questions
- Attention paid to contradictions, provincial differences, and differences between HCP and CM views

Findings

When injuries are straightforward – things seem to go well

- When patients have a visible, acute, physical injury that is clearly work-related and supported by definitive, "objective" evidence – things usually go well
- Forms, contact with WCB (via forms), remuneration, system knowledge is adequate; RTW process is straightforward

So, I mean, mostly it's just a simple injury. Like, someone burned themselves at work, or someone, you know, hurts themselves, and they get better, and they go back. Those things go smoothly – P#29, HCP, ON

- Challenges arose when HCPs treated patients with multiple injuries, gradual onset or complex conditions (e.g. concussions, certain MSK injuries), chronic pain and mental health conditions

Findings

Misaligned perspectives on the timing and appropriateness of RTW

- CMs tended to view RTW as a good thing, in virtually all circumstances
  - Push for early RTW
  - Work viewed as extension of rehabilitation

I always want to know, what is the next step? So, we are at four hours. Can we go to six after two weeks? Are we at eight after two weeks? Can I go five pounds to fifteen to thirty pounds? So, there is that natural progression of improvement and they are also maximizing their return to work. I look at a return to work as not as much an employment program, but an extension of your rehab program. So, basically, you're going to work to exercise. – P#66, CM, MB

Findings

- HCPs supported RTW but many felt that early RTW was not always appropriate, may delay recovery

And there's a real mismatch between the clinical picture from the standpoint of the treating physician to what the board deems acceptable, and I feel that they remove themselves from the realities of many workers that do not recover well from their injury. Many workers who don't receive timely treatment or their treatment outcomes are confounded by a return to work program that runs in counter-purposes....So, many cases where the return to work is premature and doesn't allow for adequate recovery, and that's usually around the lack of acceptance of ongoing musculoskeletal pain and limitations, that the board feels is no longer their responsibility. – P#62, HCP specialist, MB

Findings

- Premature RTW may delay recovery particularly for IWs with chronic pain and MH issues – but sometimes the WCB made a decision and the HCP's "hands were tied" – this led to frustration

I think she's going to fail. I think she's going to have a setback, but I feel that my hands are tied because a WSIB specialist said that this should be done. In the end, this person who recommended this has no plans on ever seeing this person again or reassessing them [...] each time you put someone back and it's unsuccessful, then that actually complicates things and makes it even less likely that they'll return to work successfully down the road. - P#8, HCP specialist, ON

- Different perspectives on RTW - suspicion that each party pursuing their own agenda (cost containment; advocacy)
- Lack of collaborative action to resolve problems and increase in adversarial relations

Findings

Not understanding the workers' compensation system

Many HCPs did not have a clear understanding of the WC system, how it functioned, or their role in it – problematic when claims became complicated

- How does the system work?
- Who makes decisions?
- How should functional limitations be determined? Work-relatedness?
- What is done with the information provided?
- What is the HCP role beyond treatment?
- What does the patient do at work? What will the RTW plan look like? HCP role in monitoring that plan?
- What to do when things go wrong?

Findings

- Some exceptions – OTs, Occupational health physicians/nurses, chronic pain specialists
- For GPs, view that there was a lack of system understanding (this was shared by CM and HCPs)

Consequences:

- Confusion about policies, procedures and decision making processes led to frustration on the part of both HCPs and CMs
- Some HCPs unsure about how to best help their WC patients
- CMs reported mistakes and omissions on forms or reports – HCPs not realizing potential impact on IW claim?
- Collaboration and joint decision-making more difficult

Findings

System rigidity

- Rules and procedures may sometimes be applied too rigidly to accommodate circumstances of workers with complex injuries and conditions

Recovery guidelines for certain conditions/injuries

If someone fractures their elbow, yes we understand the healing time is six to eight weeks. The cast is removed, and they should be progressing. That's a benchmark. That doesn't necessarily mean everybody is going to heal the same way, but they'd rather make determinations on entitlement using those independent guidelines versus the doctor's specific medical opinion. – P#12, (former CM), ON

- Rigid adherence to recovery guidelines was particularly problematic with MH and chronic pain claims – led to interruptions in treatment, patient distress

Findings

Requirement for “objective evidence”

- Many conditions have a significant subjective component – pain, psychological distress, fatigue, etc. – no test, no “objective evidence”
- Frustration when these conditions were treated like physical injuries

  Throw the physical rulebook out the window, it's not applicable to mental health. Start from scratch. Train your people, if there's mental a health issue on the file and the physical issue, go on the mental health side because the physical person (CM) does not get it. That's just for me, I feel really strongly about it...I keep on saying, a bone doesn't heal the same as the mind. – P#111, HCP, BC
- No objective evidence = IW not believed, development of adversarial relationships
- IW stigma became an additional barrier to healing and RTW

Findings

Forms

- Forms seemed to work well when injuries were straightforward
- Form-related problems identified when HCPs tried to convey information to the WCB about complex injuries and RTW problems

  e.g. Newfoundland/Labrador – injury/symptom codes

  e.g. British Columbia – electronic word limits

If someone has been in a major accident, or major work injury and has had lots of treatment, or been admitted to hospital with surgery...it's really hard to get all that in there... you're only allowed 250 characters. So if you want to start really trying to give WCB, you know, I want to do a good job for them, and tell them that this guy has done this...he's having pain here now and seems to be getting depressed...and it'll say "out of characters" – P#120, HCP, BC

- Challenges of conveying a complete picture of a complex situation

Findings

Communication challenges

- Communication challenges were identified as a barrier to effective collaboration – problems went both ways!

- HCPs not returning calls, not filling out forms properly, not providing enough or right kind of information

- CMs not returning calls, not keeping HCP “in the loop” about decision making, RTW planning, referrals to other HCPs

Findings

- Frustrations arise when HCPs had to communicate with non-medically trained personnel

In the past, when I've talked to a case manager ... they just don't really seem to understand what I'm talking about. I actually had a situation where a patient had a cervical, like a neck, cervical spine problem. And for some reason they had requested records, and there was something in the patient's chart about cervical dysplasia, like, of your cervix, the female genital organ. And they said that she wasn't covered because she had a pre-existing condition, which is completely ridiculous. And then I had to spend hours sorting this out. – P#29, HCP, ON

- Communication difficulties led to delays in decision making and treatment
- Use of IW as a go-between – not always appropriate or ideal

Findings

Exclusion from the workers' compensation system

The communication is very, very important. The physicians who are treating the patients, I think that lack of engagement is a big problem...There should be a note sent to the physician and to the specialist of the patient, saying we are sending this patient to the [speciality] Clinic. I don't think that happens and I think that creates distrust. Interviewer: Distrust on whose part?
On the physician's part. If your patient is going places that you have no control of where they're going, it feels very bad. You feel like a bad doctor. You feel like you're not treating your patient well. And then it encourages a lack of responsibility and engaging of the physician. So, think about it. You get your patient and he comes to you and he says oh, I have this appointment to go here and the physician doesn't know anything about it and it's just arranged for him.... The physician will just throw up his arms and say okay, well, if that's what they're doing, okay I guess. And then you can imagine that he sort of feels like well, I guess I'm not involved. (PP#9 HCP-Specialist, ON)

Exclusion from the Workers' Compensation System

What contributes to exclusion?

- Repeated failed communication attempts
- Lack of understanding of HCPs' role in the WC system
- Different views on RTW (timing, appropriateness)
- Perceptions of systemic rigidity
- Feelings that WC decision makers are predominately concerned with cost containment
- Funding structures (particularly for AHCPs) that make treating IWs financially unsustainable
- Use of internal medical consultants
  - Medical guidance to help with decision making
  - Quick access
  - Bridge gap between external HCPs (sometimes)

Findings

- In BC and MB – some HCPs reported using IMC as a resource
- Many did not know about IMCs or their role
- In all provinces some HCPs critical of the use of IMC – specifically their use in overturning external HCP recommendations

The bottom line is it's the medical advisor's opinion that counts, not necessarily the treating physician or the specialist that may know the patient better. But the internal decision within the WCB trumps, even, multiple care providers sharing the same concern. That's been my experience. – P#62, HCP-Specialist, MB

- Literature on RTW has a focus on collaboration and HCP involvement in RTW, yet we found a number of factors that alienated HCPs from the WC process

Findings

The broader, macro-level context is important

- Patients' access to health care services affects the RTW process
- Many IWs, particularly in northern and remote communities, do not have family doctors
- Reliance on walk-in clinics or emergency rooms – especially problematic for workers with complex conditions

  ...Depression and chronic back pain... I'm seeing them for 10 to 15 minutes out of their life and so, me, doing a WSIB form is probably not appropriate except for those patients when someone breaks their arm or some major trauma... We deal with a lot of long term issues, but they're not appropriate in the Emergency Department, that's my frustration. – P#28, HCP, ON
- Lack of follow up and continuity of care, little time to fill in forms, no background knowledge of the patient, no time for RTW planning

Take home messages, opportunities for change & improvement

- Clarity, discussion and consistency needed regarding role of HCPs

Based on the study findings the following are possibilities:

- Ongoing treatment of injury/condition
- Being generally supportive of RTW and communicating why RTW is *often* good for physical and mental health
- Flagging and addressing issues which may complicate recovery and RTW
- Identifying chronic pain or deterioration in mental health
- Communicating with the WC board about further treatment needs (e.g. counselling; occupational therapy, etc)
- Certain allied HCPs and occupational medicine specialists well positioned to provide detailed information about functional abilities, readiness for RTW or the appropriateness of certain accommodated work tasks in the context of specific work situations.

Take home messages, opportunities for change & improvement

- More information about the WC system
  - Medical schools, HCP section of website, courses for CME credits, apps

- RTW...but not at all costs – focus on safety, appropriateness, staying at work, problem solving

- Specific to complex conditions:
  - CM training in area of MH and chronic pain - steps to decrease IW stigma
  - Flexibility, not procedural rigidity (Seeing & MacEachen 2011)
  - Form flexibility
  - Reconsider “objective evidence”
  - When healing extends beyond recovery timelines – offer greater support, not punitive measures
  - Option on forms for HCPs to get support or opt out of RTW planning

Take home messages, opportunities for change & improvement

- IMCs can be a resource for CMs...and potentially HCPs? – should be used to communicate and work collaboratively with treating HCPs, not overturn medical recommendations
- The treating HCP (typically GP) is in a good position to understand factors that will complicate recovery and RTW
- This insight should be integrated into treatment and RTW planning

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