

December 2016

The role of health-care providers in the workers' compensation system and return-to-work process: Final report



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Acknowledgements

The Institute for Work & Health gratefully acknowledges the financial support of the Workers Compensation Board of Manitoba, through the Research and Workplace Innovation Program, in carrying out this project and preparing this report. However, the content of the report is the sole responsibility of the Institute for Work & Health, and the views expressed in it are those of the authors.

The authors wish to thank the participants in this study for sharing their experiences and perspectives with us.

The authors also wish to thank the members of the study advisory committee who provided feedback and input at key points of the study: Dan Holland, Ann Lovell, David McCrady, Peter Rothfels, Kim Roer, Michael Zacks and Alec Farquhar.

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The role of health-care providers in
the workers' compensation system
and return-to-work process:
Final report

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Date: December 2016

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Executive Summary

International research has generated strong evidence that health-care providers have a key role in the return-to-work (RTW) process. However, pressure on consultation time, administrative challenges and limited knowledge about a patient's workplace can thwart meaningful engagement. This multi-jurisdictional, two-year study focused on health-care providers' experiences within the workers' compensation system and their role in the RTW process.

Methods

The study consisted of three parts: (i) a document analysis of materials (e.g. policies, resources, guides) aimed at health-care providers about their role in RTW and in the compensation process, as well as interviews with key informants involved in the development of these materials; (ii) interviews with 97 health-care providers in British Columbia, Manitoba, Ontario and Newfoundland and Labrador, examining their experiences with the workers' compensation system and return to work of patients receiving workers' compensation; and (iii) interviews with 34 case managers about how they interact with, and view the role of, health-care providers in the RTW process. Our analysis sought to understand how health-care providers interact with workers' compensation boards, manage the treatment of workers' compensation patients and navigate the RTW process.

Findings

We found most health-care providers did not encounter significant problems with the workers' compensation system or the RTW process when they treated patients who had visible, acute physical injuries that were supported by clear "objective" evidence. We found health-care providers faced challenges when they encountered patients with multiple injuries, gradual-onset or complex illnesses, chronic pain and mental health conditions.

In these circumstances, many health-care providers experienced the workers' compensation system as opaque and confusing, with little clarity about their role in it. When health-care providers dealt with injuries that were complex, their views and the views of case managers were sometimes misaligned with respect to the timing and

appropriateness of RTW. Forms and recovery guidelines were viewed as ill-suited to these conditions, and communication difficulties between case managers and health-care providers made it difficult to convey important information needed for decision-making and effective RTW planning. In the absence of regular and effective communication, internal medical consultants were used to help case managers with medical decision-making. For treating health-care providers, however, this practice contributed to their further alienation from the workers' compensation system.

Administrative hurdles, disagreements about medical decisions and lack of role clarity impeded the meaningful engagement of health-care providers in RTW. In turn, this resulted in challenges for injured workers, as well as inefficiencies in the workers' compensation system.

Conclusion

This study raises questions about the appropriate role of health-care providers in the return-to-work process. We offer suggestions about practices and policies that can clarify the role of health-care providers and make workers' compensation systems easier to navigate for all stakeholders.

Introduction

Health-care providers can play an important role in the return to work (RTW) of injured workers and in disability management processes at workers' compensation boards in Canada. As part of the workers' compensation process, health-care providers are often asked to provide information about an injured worker's condition and the work-relatedness of his or her injury or illness. They are responsible for informing workers' compensation boards about the severity of a worker's health problem and what type of treatment a worker needs. They also give recommendations about a worker's ability to return to work.

Studies suggest (Kosny et al, 2011; Brijnath et al, 2014; Mazza et al, 2015; Kilgour et al, 2015) that health-care providers can struggle with managing RTW consultations. Time pressures, administrative challenges and limited knowledge about a patient's workplace can thwart active engagement. This two-year study focused on health-care providers' experiences within four Canadian workers' compensation systems and their role in return to work after injury or illness.

The study sought to address three broad questions:

- What is the role of health-care providers in the workers' compensation system and in the RTW process?
- What challenges do health-care providers face?
- What can help engage health-care providers in the workers' compensation and RTW process?

Methods

An exploratory qualitative research approach was taken to understand health-care providers' experiences with their respective provincial workers' compensation boards and their role in the RTW process. The study consisted of three parts:

- (i) a document analysis of materials (e.g. policies, resources, guides) aimed at health-care providers about their role in RTW and in the compensation process, as well as interviews with key informants involved in the development of these materials;

- (ii) interviews with health-care providers examining their experiences with the workers' compensation system and return to work of compensation claimants; and
- (iii) interviews with case managers about their use of medical evidence, their interactions with health-care providers, and their views of the role of health-care providers in RTW.

The University of Toronto Research Ethics Board reviewed and approved the study protocol. This final report focuses on the second two parts—the findings from interviews with health-care providers and case managers. The findings from the first part—the document analysis—were presented by Dr. Agnieszka Kosny at a November 2016 seminar held at the Institute for Work & Health:

<http://www.iwh.on.ca/plenaries/2016-nov-01>

Recruitment and sampling

The sample included case managers and health-care providers from urban and rural areas in four provinces (British Columbia, Manitoba, Newfoundland and Labrador, and Ontario). These case managers and health-care providers had varying volumes of injured worker patients to ensure diversity of experiences and interactions with the workers' compensation boards.

We used a modified grounded theory approach for the collection and analysis of data. That is, sampling of participants was done based on analytical grounds, and emerging concepts and recruitment continued until saturation was reached and no new themes were forthcoming.

Health-care providers were recruited through clinics and health-care centres, as well as through the researchers' pre-existing contacts in professional networks and medical associations. Information letters explaining the research and inviting health-care providers to participate were distributed through medical associations. Recruitment ads were mailed and e-mailed to members, and were also placed in medical newsletters and on social media (Twitter, LinkedIn).

In order to be eligible, health-care providers had to have seen at least one patient with a work injury in the previous year. Those interested in being interviewed contacted the research team. Health-care providers were also asked if they knew

professional peers who might be interested in participating and, if so and with the consent of their peers, were asked to provide contact details to the researchers.

In addition to the recruitment strategy described above, we also recruited some health-care providers and case managers through the workers' compensation boards. Workers' compensation boards in British Columbia and Manitoba agreed to help with recruitment. Workers' compensation boards in Ontario and Newfoundland and Labrador declined to help with recruitment and did not wish that their current staff participate in the study. As a result, only case managers working in private companies were recruited in Ontario, although they may have been former workers' compensation case managers. No case managers were recruited in Newfoundland and Labrador.

In participating workers' compensation boards (namely, in British Columbia and Manitoba), the organization provided the research team with a list of health-care providers and case managers to contact after gaining the consent of these individuals. Researchers directly contacted those on the list in order to render potential participants less identifiable to those who had referred them. Limits to confidentiality were discussed with participants and included in the study information sheet.

An e-mail was sent to the appropriate individuals (who were identified by the researchers or who self-identified to the research team) with information about the study. This was followed up by phone calls to determine if the individuals were interested in participating and to see if they had any questions. An invitation was then issued to participate in the study along with a consent form. Depending on their role, health-care providers were offered an honorarium of \$50 to \$100 to thank them for their time. Due to rules at the workers' compensation boards, some participants declined the honorarium.

Procedure

One-on-one, semi-structured interviews with participants were conducted between May and November 2015. Experienced interviewers were hired in each of the four provinces to conduct the interviews. An interview guide was developed collaboratively with the research team and the study advisory committee. The advisory committee included representatives from several workers' compensation boards, workers, health-care providers and employers.

Interview questions focused on the ways in which health-care providers were involved in the RTW system, their experience working with patients who had been injured at work (or, in the case of the case manager interviews, their experience managing injured or ill workers' files and working with both injured workers and health-care providers), the interactions of the health-care providers with the workers' compensation boards in their respective jurisdictions, including successes and challenges, and the interactions of the health practitioners with other stakeholders (e.g. case managers, employers, allied health-care providers). Case managers were asked about their experience interacting with health-care providers, injured workers and employers.

The interview schedule allowed for follow-up questions, probes and new avenues of inquiry. Interviews were held in person or via telephone, depending on the participant's location, work schedule and preference. Written consent to record the interview was obtained from all participants prior to the start of the interview. Interviews lasted between 30 and 60 minutes. All interviews were audio-recorded and transcribed verbatim.

Participants

Ninety-seven health-care providers and 34 case managers were interviewed. Forty-one per cent (n=40) of the health-care providers and 38 per cent (n=13) of case managers were female. The health-care provider sample included 59 general practitioners (GPs) (of which nine practised internally for workers' compensation systems at the time of data collection), 19 allied health-care providers, and 19 specialists (Table A). Of the 97 health-care providers, 34 per cent (n=33) were from Ontario, 29 per cent (n=28) from British Columbia, 21 per cent (n=20) from Manitoba, and 16 per cent (n=16) from Newfoundland and Labrador.

Some participants had more than one role; for example, GPs who went on to specialize in occupational health or chronic pain. Many health-care providers had experience working in different settings throughout their career; for example, as a walk-in clinic doctor and a GP. This ensured diverse perspectives on workers' compensation processes and RTW. Almost half of the health-care providers had over 15 years of tenure, whereas 20 per cent had been practising less than five years. More than half of the health-care providers (67 per cent) practised in large city centres (>100,000); the rest were from medium-sized and small cities and towns.

Of the 34 total case managers, none were from Newfoundland and Labrador (due to recruitment restrictions) and those from Ontario were employed by private organizations (albeit some with former workers' compensation board experience). Thirty-three per cent of the case managers had over 15 years of experience as case managers or RTW specialists (within or outside of workers' compensation boards). Twenty-two per cent had less than five years' experience. Case managers worked in a range of roles including vocational rehabilitation, adjudication of long-term claims and adjudication of mental health claims.

Table A: Type and number of health-care providers and case managers

Type of health-care provider	Number
Total*	131
General practitioners (Internal health-care providers to workers' compensation boards, emergency room practitioners, walk-in clinic practitioners)	59
Allied health-care providers (Occupational therapists, physiotherapists, chiropractors, 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.	

Data analysis

A thematic content analysis allowed us to organize data systematically and to identify, analyze and report themes. Transcripts were entered into NVivo (qualitative data analysis software, QSR International Pty Ltd. Version 10, 2012) for data storage and coding.

In the first phase of coding, three researchers (Agnieszka Kosny and two research assistants) read a sample of interview transcripts and established a preliminary list of codes. The research team reviewed the content assigned to these codes, and then developed a coding manual containing a definition for each code and an explanation for how its content would apply to the research objectives.

Transcripts were then coded in two rounds by two researchers. Once the first round of coding was applied, the coded text was sent to the second reviewer to add additional codes or to identify and discuss sections that may have been miscoded. Common themes and concepts across codes that captured key insights were identified. Any discrepancies in coding and interpretative differences were discussed and resolved by the research team.

Data pertaining to each of the codes was then reviewed and common themes were identified. The focus was not strictly on prevalence, but also on whether or not the theme captured key insights in relation to the research question. Analysis and interpretation examined core experiences, underlying assumptions, shared and divergent perspectives, contradictions, silences and gaps (Poland & Pederson, 1998) in the data. A constant review of data and moving back and forth between the data and developing themes led to a deeper understanding of health-care providers' experiences, challenges and strategies regarding compensation processes and RTW (Glaser & Strauss, 1967). The following key findings and discussion address the three central research questions:

- What is the role of health-care providers in the workers' compensation system and in the RTW process?
- What challenges do health-care providers face?
- What can help engage health-care providers in the workers' compensation and RTW process?

Findings

What is the role of health-care providers in the workers' compensation system and in the RTW process?

During each interview, health-care providers and case managers were asked what they believed the role of health-care providers to be currently and what it should be ideally. Almost all participants agreed that the health-care provider's key role is to diagnose and assess the injury and provide the patient with treatment. Beyond these functions, there was a great deal of variability in the views about their role. For example, some health-care providers viewed their role as being fairly minimal in the RTW process, whereas others viewed it as essential. Some health-care providers took a holistic view and considered how the injury and the workers' compensation process affected the whole family:

My experience has been that we actually don't do very much. And it's mostly because it's kind of a limited turnaround time—if I'm counselling patients and completing paperwork, whenever they can bring it to us, or if they're coming specifically to open up a new case, and kind of like the first doctor's report and follow up report. – P#83, health-care provider, MB

I think it's a fairly essential role. I do know that a number of health-care providers are possibly uncomfortable with assuming this role. But I think when you're talking about transitioning back to work after any kind of injury, whoever's on the receiving end, such as the employer, does need some guidance on what is appropriate and not appropriate. It's only health-care providers that can provide information on they can probably tolerate X, but if they start feeling more pain, then this could be a sign of them worsening. That, versus at times, it's going to be they have an injury that you're not going to actually cause further structural damage to, and it's just going to be progression based on symptoms. I think information like that, like the fear or possibility of doing further permanent damage, is really important for the receiving people to have, and we're the only ones that can provide that. – P#8, health-care provider-specialist, ON

I try to palliate symptoms as best I can. Actually, one of the things that I do, which is a big part of my job, is to try to hold families together. Because, with the financial strain, with the strain of the change in personality, the fear, the anger,

injured people are very easily angered, depressed, fearful people, have trouble controlling their anger, the marriages break apart. – P#36, health-care provider, ON

In general, there was some confusion among health-care providers about their role within the workers' compensation system and in the RTW process. While health practitioners understood their role to be treatment of injury, there was far less clarity about their role in determining functional limitations, RTW planning, helping the worker navigate the workers' compensation process and decision-making about readiness to return to work. The vast majority of health-care providers felt that it was not their role to contact and communicate with the employer or to evaluate the suitability of available work duties.

Interviewed case managers generally wanted health-care providers to provide them with objective medical evidence and information on a patient's functional limitations. There was some disagreement about whether health-care providers should be more involved in the RTW process. Generally, while case managers wanted health-care providers to be supportive of RTW, they did not view health-care providers as having a role in determining the appropriate accommodated work or recommending jobs that the injured worker could or could not do:

Somebody with a back claim for a back strain and the doctor keeps them totally off of work. I am not faulting the doctor because it could have been the worker only has duties at work in the oil field. However the doctor, it's not up to them to find this out.... The doctor should not have put [him] totally off of work but just listed restrictions, no heavy lifting, for example. So they take it a step further and they adjudicate the claim for us, adjudicate and case manage the claim for us, which they should not be doing. – P#79, case manager, MB

But it's not up to the physician to make the decision that they can't work. It's up to the physician or the treaters to tell us what the function level is. If they say the function level is bedridden because they have a severed spine, then great. That is good. But if they have back pain and they are saying they can't work, well, I'm not sure of that. – P#66, case manager, MB

Part of the challenge with having health professionals play an important role in RTW and the workers' compensation system more generally had to do with a belief, held by some case managers, that health-care providers are advocates for their patients.

In being advocates, it was believed, they do what the patients want and not necessarily what is medically indicated. For most health-care providers, when they discussed advocacy, the term took on a different meaning. Many practitioners did view themselves as advocates for their patients, but this typically did not mean blindly doing what the patient wanted. Rather, advocacy involved acting in a way that was in the best interest of the patient:

When a doctor writes that they don't think a patient should go back to work, or ... when we write that we think they should stay off for one week and then return, whatever we write, you know, we don't do that lightly.... I don't take people off work just for fun, or because I'm being nice or bored, I take them off because I think they need the time off – P#29, health-care provider, ON

One health-care provider described the tension that arose around the issue of advocacy:

The College of Physicians and Surgeons of Ontario regulations stipulate that a physician has to play an advocacy role for a patient. Yet what the WSIB does is completely ignores any doctor who is taking care of a patient precisely because they are advocates. So this just makes this an absurd situation. This is the kind of thing that Franz Kafka would have dreamt up. We're supposed to be advocates but we're not supposed to be advocates. And, the assumption is that we're not going to be objective about the patient. Oh, right, as if the doctors who used to be on their payrolls or the nurses who are still on their payrolls are objective, when their work incentives are related to how many people can they kick off the payroll. – P#35, health-care provider-specialist, ON

While only a few health-care providers felt this level of frustration, issues of objectivity and advocacy were central to the discussions that health-care providers and case managers had with researchers about their role in the workers' compensation system. Different understandings of what advocacy meant and whether objectivity was possible or desirable led to different views about the health-care provider's role.

Some case managers believed misconceptions existed in the medical community about the role of health-care providers; namely, they believed health-care providers and patients held the view that the health professional was the decision-maker. Most

case managers were emphatic that health-care providers are not the ones who make decisions about RTW readiness and other workers' compensation issues:

I think there is a bit of an idea that the physicians out in the community are directing all this. But really what the physician in the community is doing is just providing opinions just like we [internal medical providers] are providing an opinion. And ultimately, I think the patients still think that the physician should be directing everything which isn't the way the workers' compensation board actually works. The case manager is supposed to be the judge and directing the case and the physician out in the community is supposed to be providing information. – P#71, health-care provider, MB

Despite the view that the health-care provider was not the one who should be directing the process, a number of case managers felt that, when health-care providers did provide input on recovery or RTW, they had a profound influence on their patients. In this manner, health-care providers, it was thought, had a major impact on injured workers' RTW trajectories:

It's huge for us, because a lot of times what will happen is the GP really sets the tone, and that's one of the first questions I usually ask a client in my intake, is what does your family doctor feel about you returning back to work, or you being a part of this program at this time. – P#119, health-care provider-allied, BC

Because it was felt that health-care providers could have a major influence on their patients' recovery and RTW expectations, many case manager felt it was necessary to educate health-care providers on the importance of RTW and their role in the process. However, as is noted above, this process may have been thwarted by the myriad (sometimes conflicting) views about what the role of the health practitioner should actually be.

In summary, there was a wide range of perspectives among health-care providers and between health-care providers and case managers about the role of health-care providers in the workers' compensation system and in the RTW process. This lack of consensus also extended to what participants believed to be ideal roles for health-care providers.

What challenges do health-care providers face?

A key part of the study was to determine what sorts of challenges health-care providers may face while treating workers' compensation patients and during the RTW process. *For many health-care providers, in many circumstances, things are working well.* Most health-care providers did not have any major problems with the workers' compensation and RTW process when they treated patients with acute, physical injuries that were clearly work-related and supported by "objective" evidence.

In these instances, typically the worker sought and received treatment, the health professional provided evidence of the injury and its work-relatedness to the workers' compensation board (via a form); the worker then returned to work quickly without much intervention or necessary accommodation. In such circumstances, the level of knowledge that the health-care provider had about the workers' compensation system was adequate, the nature of contact and interaction with the workers' compensation board was appropriate, forms were easy to fill out, and the reimbursement process was straightforward:

I think if it's pretty straightforward, it's easy ... like things go according to plan. The patient gets seen by a specialist. I've had patients that are seen really quickly by specialists, which is extremely helpful and as long as we're on the same page, things can go relatively smoothly – P#99, health-care provider, BC

So, I mean, mostly it's just, like, 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, health-care provider, ON

Challenges came to the forefront when health-care providers encountered patients with multiple injuries, gradual onset or complex conditions (for example, concussions, certain musculoskeletal injuries), chronic pain and mental health conditions (either as a primary or secondary diagnosis). Depending on the type of health-care provider and specialty, the health practitioner's contact with these types of patients was either regular or sporadic. For example, participating chronic pain specialists or psychologists almost exclusively saw patients with complex conditions and prolonged claims. General practitioners tended to see patients with a mix of straightforward and complex conditions.

We identified six key challenges encountered by health-care providers, primarily arising when health-care providers treated injured workers with complicated injuries and prolonged claims.

Challenge 1: Misaligned perspectives between case managers and health-care providers on the timing and appropriateness of RTW

The case managers in this study had strong views about the benefits of return to work. RTW was described as desirable for social connection, income, structure and recovery. While some case managers discussed recovery as being important, most focused on the necessity and benefits of RTW:

Work's important for people. Work is for self-esteem, work is for social contacts, work is for structure in your life, it's for making good money. There's a lot of good reasons why it's good for people to work. – P#93, case manager, BC

I always want to know, what is the next step? 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, case manager, MB

While health-care providers also believed strongly in the benefits of RTW and echoed many of the same sentiments, they were more nuanced in their descriptions of when RTW was appropriate and when the patient needed time off to recover. For example, a number of health-care providers noted that, when patients suffered from complex injuries such as a concussion or serious mental health conditions, early RTW might not be appropriate and could do more harm than good. Ignoring symptoms such as severe pain, serious depression or strong medication and pushing workers into an unsustainable RTW situation could set a worker up for failure and, ultimately, delay recovery:

Really, I put my patients in a position to fail because I find that they're going to go back, and this person is going to be reintegrated before she's ready and go into a noisy, busy, fast-paced environment. 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, health-care provider specialist, ON

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. There's aggravations... To be on your feet, even if you're not doing significant exertions, is not necessarily what the person needs at the time they're trying to rehabilitate injury. 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, health-care provider specialist, MB

Many interviewed health-care providers felt that they had important background knowledge about the injured worker, including factors that may impede or facilitate RTW, and this information had to be considered in RTW planning. Further, treating health-care providers noted that they would continue to have involvement with the patient long after the workers' compensation board was "done with them." Thus, health-care providers tended to consider what was best for the patient in the long term, beyond an initial RTW attempt.

However, some case managers saw this long-term relationship as potentially problematic, and they were wary of health-care provider involvement in RTW planning and decision-making. It was believed that, in some cases, health-care providers inappropriately advocate for their patients and make decisions about RTW that are not based on availability of jobs or patient limitations:

That could open a can of worms you don't really want to go with. I find the biggest problem here, is that doctors are having an opinion about return to work. While they first of all don't know the job, second are based...their opinion is

based on just information the patient provided, and the third thing that I think is very important is that they have the doctor-patient relationship, so are they willing to say things that are not... like [they are] favouring the patient... because they want to keep their relationships as well, and that's hard. – P#93, case manager, BC

These somewhat divergent views on RTW created tension and suspicion among health-care providers and case managers. On the one hand, case managers sometimes felt that health-care providers were suggesting delayed RTW because that was what the patient wanted, they did not appreciate the benefits of RTW, or they were too busy to design a comprehensive RTW plan. On the other hand, health-care providers sometimes felt that case managers did not have the best interests of their patients in mind, were predominantly concerned with cost containment, and did not consider individual situations that might necessitate a delay in RTW. In the context of complicated and prolonged injuries, such discordant views had the potential to decrease collaboration and to lead to adversarial exchanges that could alienate case managers and health-care providers from each other.

Challenge 2: Not understanding the workers' compensation system

A key issue raised by many study participants related to health-care providers' lack of understanding and training in the area of occupational injury and workers' compensation. With the exception of occupational health and chronic pain specialists, most health-care providers had a limited understanding of how the compensation system operated and their role within it. It was noted by many participants that health-care providers (physicians, specifically) received almost no training in medical school related to workers' compensation, occupational health, work injury management, functional assessment and RTW. A number of health-care providers described difficulties they faced when trying to unequivocally determine work-relatedness or functional limitations. Physicians rarely had a good understanding of a patient's workplace or the demands they would face at work. Yet, physicians were asked about an injured worker's readiness to return to their job:

Um... ya... I would like... more kind of OT [occupational therapy]-based idea, I think it would be really helpful. I think we'd be able to derive more evidence of function, right? And say hey, you can do this, this is good. The problem is sometimes it's misleading... you can do one 20-pound lift, but can they do it

sustainably at work, like it doesn't test that necessarily, so sometimes... Like I've had a couple patients have these OT assessments, and there's not a realistic assessment of how can they endure a lot of these repetitious movements or is just one time they can lift 20 pounds... It would have to be really applicable to workplace and realistic... Is it actually?... Is there real application? – P#115, health-care provider, BC

I think certainly [a challenge is] assessing whether people are fully capable of going back to work, in their previous role or a modified role, because often we haven't done those jobs. And so there's only so much that we understand about their...the requirements that they need to be in the job, if that makes sense. And what the physical status of others that are currently doing that job looks like. So we're going by a lot of patient's self-report and so that can sometimes be a challenge. "Oh I can only pick up let's say 20 pounds" or something, well like is that true? Is that too much for you, or too little? Sometimes people are motivated to stay off of work, they're also motivated to go back to work more quickly for whatever reason. So, I have to truly be able to assess how prepared they are to go back to work, and to be able to weigh the risks and benefits of that and the risk being re-injury, right? That's probably the most challenging part. – P#104, health-care provider, BC

Many health-care providers suggested that they learned about the system gradually and informally, often through trial and error or from more senior physicians. In most cases, health-care providers did not understand key entitlements and rules of the workers' compensation system in their jurisdiction, how decisions were made, who made them, and what happened to information and reports when they were submitted to the board. Many health-care providers did not know how to get help when they needed it (with RTW or entitlement questions, for example):

I'm really curious to know what the plan looks like from WorkSafe. Like understanding where they're coming from. What is their plan? What is it that they're...? Understanding the bigger picture would help us be able to facilitate that better, because we're only coming from a point of functionality for our patient. To understand what the WorkSafeBC is actually all about, and who they're serving, and what their goals are, would help us facilitate those goals – P#109, health-care provider-allied, BC

In each of the jurisdictions included in this study, forms ask health-care providers to comment on a worker's ability to return to work and recommend certain accommodations (reduced work hours, lifting restrictions, etc.). When health-care providers provided this information but the workers' compensation board made a different decision, this often led to frustration on the part of the health practitioner. While communication issues contributed to this frustration (discussed below), an unclear understanding of system processes was also to blame. As was discussed earlier, some health-care providers assumed they were the decision-makers about RTW issues and, as such, were confused and frustrated when their recommendations were not followed:

I have been frustrated when I've requested an imaging, and then [it's] rejected. It's hard to get it rejected from someone who isn't a physician, and of course it doesn't stop you from ordering it through the MSP system, but it's frustrating when you're trying to expedite an MRI and it's refused by a case manager which isn't a physician. – P#115, health-care provider, BC

Case managers also described health-care providers' (particularly physicians') lack of knowledge about the workers' compensation system. Case managers said that often they did not receive the sort of information that they required from health-care providers about worker limitations and capabilities. For example, health-care providers sometimes gave restrictions related to an injured worker's work tasks instead of focusing on functional limitations. Case managers described why providing functional limitations was difficult for physicians:

I think a lot of it boils down to [this]: We put physicians in difficult positions by asking them to respond to fitness for work or identify restrictions when for the most part that's not their training. They're not doing functional assessments say, for example, the way a physical therapist or an occupational therapist would. But because of the way the system is designed, we oftentimes don't have a chance but to go through a physician so I understand why they get frustrated. They get frustrated with the phone calls, and they're frustrated with the paperwork. They're frustrated because we're asking them questions that they don't necessarily have the ability to answer – P#77, case manager, MB

A lot of times it's just understanding the nature of the job. They're not experts. They're not ergonomists. They haven't studied ergonomics, kinesiology, or done

job demands analysis. Even just trying to get, for me, just a basic understanding of certain jobs, and even then because what's in writing, and what actually happens on the floor, are two different things. – P#12, case manager, ON

Case managers were sometimes frustrated when health-care providers got involved in activities that they viewed as falling outside of the practitioners' expertise; for example, advising on RTW readiness or intervening if they felt the workers' compensation board was inappropriately pushing RTW:

They can involve themselves as long as they provide a medical opinion in regard to the research. That's all they need to do; they don't need to get involved if we are pushing Suzy or John too hard. They [can] have their say when they've developed the resources. Further involvement is not required. Their purpose is to provide us with restrictions. – P#79, case manager, MB

A lack of system understanding had a number of consequences. It left some health-care providers unsure about how to best help their workers' compensation patients. For example, some health-care providers were not sure what to do when a RTW was unsuccessful or when a patient's treatment was stopped. Case managers also reported that mistakes and omissions were made on forms and reports. It is possible that health-care providers made these mistakes and omissions without realizing the potential impact this had on an injured worker's claim. Confusion about policies, procedures and decision-making processes also led to frustration on the part of both health-care providers and case managers. This, in turn, made collaboration and joint decision-making difficult.

Challenge 3: System rigidity

One of the problems identified by health-care providers in this study related to perceived system rigidity. Health-care providers described several instances where workers' compensation rules and procedures lacked the flexibility to accommodate the circumstances of workers with complex injuries and conditions. A number of health-care providers described workers' compensation recovery guidelines that governed how long workers with a particular injury or illness should take to recover. They explained that once a patient's recovery period extended beyond the standard time, often there were consequences for the patient. For example, payments for treatment would cease or the patient would be instructed to return to work and his or her benefits would be cut. It was noted that the guidelines failed to consider

individual circumstances and co-morbid conditions, and were generally not suitable for multi-causal, complex injuries:

The problem with compensation is that they take that period of recovery. Probably they have a list of recovering time for such and such a thing and so on, but they are tight on that. They don't give you the possibility that it could be less or it could be longer. So, in that case, for example, when I have that situation, I have to be not only a doctor; I have to be a referee between the case manager and the patient, the worker. – P#80, health-care provider, MB

What the board lately likes to do is we have these independent medical guidelines, and they're using those guidelines over and above a treating physician's opinion. You see that's what's happening. 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, case manager, ON

One health-care provider explained that interruptions in treatment were particularly problematic for individuals with mental health conditions who would experience setbacks in recovery as they went through appeals and then, sometimes, had to change health-care providers:

I think one of the biggest problems, that all of my clients have had, and I'm talking about the long-term... two years or longer... clients with mental health, they all have four to five different psychologists, because what happens, is they would be approved 10 sessions, and then it's done. Then they go down the line, they go to someone else, and then they have to start all over again. So there's no continuity, and that is also part of getting distrust in the system. People don't trust the system. Because they know that's going to happen. – P#112, health-care provider-allied, BC

Many health-care providers felt that it was counter-therapeutic to treat mental health conditions in the same way as physical health conditions. Mental health conditions required a different approach, one that recognized the variability of recovery trajectories:

Throw the physical rulebook out the window, it's not applicable to mental health. Start from scratch. Train your people, if there's mental health issue on the file and the physical issue, go on the mental health side because the physical person [case manager] does not get it. That's just for me, I feel really strongly about it, is I keep on saying, a bone doesn't heal the same as the mind. – P#111, health-care provider, BC

Another issue raised by health-care providers related to the adequacy of forms for complicated conditions. While most health-care providers felt workers' compensation board forms were adequate for straightforward claims, form-related problems were identified when health-care providers tried to convey information to the workers' compensation board about complex injuries and prolonged claims.

Many of these issues were related to form design. For example, forms in Newfoundland and Labrador necessitate that health-care providers pick codes that correspond to "subjective reports," "objective findings," "diagnoses" and so on. Health-care providers in that province described encountering difficulties when their patient had multiple injuries, complicated restrictions or episodic symptoms. In British Columbia, health-care providers described electronic forms with character limits that cut off descriptions of injuries or symptoms, sometimes without the health-care providers' knowledge:

You only have a few lines. 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, and if you're on an electronic medical record, I think it always said you're only allowed 250 characters. So if you want to start really trying to give the workers' compensation board, 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, health-care provider, BC

Some health-care providers also noted that they were not able to look up information on forms they had submitted previously and that they had to re-enter information repeatedly, even when a diagnosis or treatment path remained unchanged. This became tedious and time-consuming when dealing with complex and prolonged claims. Generally speaking, when faced with complex claims and difficult RTW situations, health-care providers found workers' compensation forms to lack the

flexibility to allow a full explanation of the situation facing the worker. This, in turn, could lead to benefit cessation and treatment denials for injured workers.

Another issue raised by health-care providers related to the strict requirements for objective evidence of disability. Health-care providers noted that for conditions such as depression, anxiety, chronic pain and some musculoskeletal conditions, it was not possible to provide objective proof of disability or its work-relatedness. A physician from British Columbia described the challenge with subjective issues such as fatigue when considering the appropriateness and timing of RTW:

For some of the oral drugs that cause fatigue, even for that it's a bit murkier about how to gauge... how tiring is it to do a particular job, relative to the fatigue they're already experiencing. Sometimes, it's a short-term side effect but maybe it's a chronic one if they're still on maintenance... They're just continuing on an oral medication for a period of time... How much fatigue can you objectively demonstrate, that says that that correlates with the inability to do a particular job is much more difficult. – P#100, health-care provider specialist, BC

Conflict occurred when, for example, health-care providers indicated on forms that a worker needed time off because of fatigue or pain, yet from the perspective of case managers, these were not appropriate reasons to delay RTW. A number of case managers noted that pain was subjective and, as such, was not an appropriate form of evidence. This was also described by an allied health-care provider who worked with the workers' compensation board:

And another challenge is that they don't always understand the programs... or the WorkSafeBC process. So, they'll make recommendations or they'll say well they need another two weeks off because they're still in pain. And WorkSafe, like we need an objective reason for someone not to participate, and pain is considered subjective. And so if a doctor's just saying "pain, pain pain", well then we don't really have any information to pass on to WorkSafeBC. – P#122, health-care provider-allied, BC


Health-care providers reported that, when a patient's condition did not "fit" workers' compensation system criteria and policies, this resulted in claim denials, adversarial relationships between injured workers and case managers, and stigmatization of the injured worker. Patients whose recoveries exceeded standard guidelines set by the workers' compensation board or whose conditions lacked "objective" evidence were

sometimes viewed as malingerers by case managers (and occasionally by health-care providers). This ultimately had a negative impact on injured workers' mental health and recovery and became an additional issue that health-care providers had to deal with during the treatment process.

Challenge 4: Communication

A number of other studies have pointed to communication difficulties between health-care providers and workers' compensation boards (Kilgour et al, 2015; Soklaridis et al, 2011; Kosny et al, 2015). Similarly, in this study, communication challenges were identified as a barrier to effective collaboration. Information was predominantly exchanged via faxes and forms. In part, this was due to a need for official documentation of decisions and recommendations. To speak on the telephone and then document everything discussed in writing was unduly time-consuming for many health-care providers.

Case managers explained that they often had difficulty getting information from health-care providers. Forms that they received were not complete, contained scant information or were delayed by several weeks. Several health-care providers noted that forms had to be signed by patients, yet consultation time was too brief to fill in the form comprehensively while the patient was at the appointment. This meant that the form had to be filled in very quickly while the patient waited or the patient would have to return to the office to sign it. When case managers received forms that were lacking detail, calls for clarification or to discuss a patient's progress were often not successful:

 I can give you a scenario when I tried to contact a GP multiple times... I was brushed off by the MOA [medical office assistant] saying he's too busy, put it in writing and send it to me. I said, "Really I can't, I need an answer." So they brushed me off and never did call me – P#96, case manager, BC

So I don't know what it is, why it takes so long... One, for example, just was at team meeting talking about the last time the worker was seen by this doctor is March... I'm still waiting for that report... and in the meantime he's gone and started a new job, rather than going to his pre-injury job, but I still don't know what his physical conclusion is. Like has he recovered? Is he still... you know... I don't have the answers, and I have no way of finding out. – P#98, case manager, BC

One hears it again and again, doctors are very busy, and they don't have time to respond, and only after several attempts will they then provide a response. Which is fine, as long as it's comprehensive enough, but then if you have to go back and ask for more information because they didn't provide enough information the first time around. So I think the main challenge seems to be around just their time availability. – P#3, case manager, ON

Health-care providers also described difficulties reaching case managers when they had questions or needed information. Several health-care providers reported leaving messages on answering machines that were never returned and delays in decisions about their patients:

I think the challenge day to day... is just the time... the turnaround time. They are not always very quick to give us information regarding accepting files. I've actually had situations where I've seen somebody because there's a condition that needed treatment, assumed that the claim was accepted for months... like two months, even. Then got a rejection letter saying the claim was not accepted and anything beyond the initial report would not be covered, and it's a little bit ridiculous to put somebody in that situation where you have such a long period of time with no response... – P#90, allied health-care provider, MB

Health-care providers also said they were sometimes frustrated when they spoke to case managers who had limited medical knowledge. Explaining medical evidence, the background to a particular condition or recommended treatment to a case manager without medical training sometimes resulted in frustration and confusion:

I find... in the past, when I've talked to a case manager or whoever else, 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, health-care provider, ON

Issues also arose when injured workers saw multiple health-care providers (for example, a physiotherapist and a family physician). Health-care providers reported that they rarely received information about the treatments and recommendations that

the patient was receiving from each health-care provider. A number of specialists interviewed as part of this study also noted that it was common for them to submit an assessment to the workers' compensation board but never hear about the outcome of the claim or what the family physician had recommended. While most health-care providers said that ideally there would be collaboration and a sharing of information among all the health professionals seeing the injured worker, this rarely seemed to occur. Communication shortcomings between health-care providers were due to different communication styles (e.g. length and detail of reports) and practical issues (e.g. hours of availability). Some health-care providers also reported that they did not have a good understanding of the treatment modalities used by allied health-care providers and this impeded communication and collaboration.

One outcome of the communication barriers between health-care providers and case managers was a delay in decision-making that could have negative consequences for injured workers in terms of treatment approvals, decision-making and vocational rehabilitation. A case manager gave an example:

I wanted something done really quickly, because I had a wanted a functional assessment for a job target for a person I wanted to get in school. Well we missed the date, and I said, "We really need it done within three days". Well there wasn't a provider who could do it in three days. So he didn't get into school... He didn't go there; we still haven't done anything, I think he's stalled now because that was that one program which started a few months ago; we missed it. – P#96, case manager, BC

Communication barriers also sometimes resulted in case managers and health-care providers using the injured worker as a go-between among all stakeholders. When some case managers, for example, did not receive needed documentation, they described telling injured workers to get information and forms from their doctor. Health-care providers also sometimes received case manager instructions or decisions via their patients:

It's the second-hand information... I'm not sitting on the other side. The person may have a fantastic person dealing with them, but the person doesn't hear them properly. They come in and they say, oh, I'm supposed to go back to work. I'll be denied my... or else I won't get any more than three days of more coverage. I hear these things sometimes and I just don't know what... I have no

idea because there is nothing in writing. It's all just the word of the person saying what they were told by their claims person. – P#30, health-care provider, ON

Health-care providers also described injured workers relaying information from employers or other health-care providers:

Because often the patients go to the physiotherapists who tell them something... that the patient then communicates to me and I have no direct communication with the physiotherapist so I don't know... Did the physiotherapist say this? Did they make it up? And they're saying, 'The workers' compensation board adjuster is saying this to me' and I'm not getting any communication like that.... The patient comes out and says, 'The physiotherapist says I need another four weeks of physio... I need you to approve.'... I should be getting that directly from the physio... I think it would be helpful if the physio saw my notes, and if I could see the physio notes... So we all know what's going on... to have more coordinated care. And also so that we're giving the same message to the patient. – P#113, HCP, BC

The patient as “go-between” seemed like a direct consequence of a lack of effective communication between key stakeholders in the system (case managers, employers, health-care providers). A number of participants noted that using injured workers to relay information often resulted in problems. For example, workers who were in pain or taking strong medication were not always able to remember or understand details of what their health-care provider or case manager said. This could lead to misunderstandings, delays and incorrect information being conveyed to key decision-makers.

Challenge 5: Exclusion from the workers' compensation and RTW process

Many of the challenges identified above led to an exclusion of health-care providers from the workers' compensation system and RTW process. For example, repeated failed communication attempts or a lack of understanding of health-care providers' role in the workers' compensation system led to less engagement among health-care providers. Similarly, different views on RTW, perceptions of system rigidity and feelings that workers' compensation decision-makers were predominantly concerned with cost containment seemed to work against collaborative decision-making. Health-care providers described instances when they were excluded from decision-making or never found out about decisions that were made after they submitted forms or

requests. One Ontario health-care provider described how he felt when the workers' compensation board sent his patient to another doctor at a regional evaluation centre without first discussing it with him, the treating physician:

The communication is very, very important. The physicians who are treating the patients, I think that lack of engagement is a big problem... I think there should be a note sent to the physician and to the specialist of the patient, saying we are sending this patient to the hand 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.' – P#9 health-care provider-specialist, ON

Many interviewed case managers described a heavy reliance on internal medical consultants – typically medical doctors who were hired by the workers' compensation board to help case managers make decisions and interpret medical evidence. For case managers, these consultants played a number of important roles and, importantly, were familiar with the workers' compensation system:

Essentially every one of our internal providers here are very helpful. They are knowledgeable and they see things a little bit differently because they have been brought into the workers' compensation board and they have knowledge in more detail of what the act and policies are. So they understand how we make our decisions, they are not there to provide treatment, they are not there to provide or specifically make a diagnosis as far as acceptance and non-acceptance. That's a case manager's role. So they review the medical findings that are on the claim that are provided from the treating practitioners in the community and then they look at, based on the mechanism of injury and the accepted diagnosis for the workplace injury, if surgery is recommended. So first off, is this in the

best interest of the worker, is it appropriate and the need medically related to the specifics of the work injury? And then if I'm asking if there may be a pre-existing factor impacting on the worker's functional recovery, these are things that I would request if there is not enough clarity from what I receive from the treating practitioners. So they are there as a guidance, a tool to assist us in clarification of medical information. – P#68, case manager, MB



Case managers described having easy and regular access to internal medical consultants. They accessed the consultants' expertise when they did not understand a health-care provider's report, to check whether a proposed treatment or recommendation was "correct" and to help them make a claim-related decision. Case managers also tended to view internal medical consultants as being "independent" and not influenced by the pre-existing doctor-patient relationship.

Only some health-care providers interviewed as part of this study knew that internal medical consultants were used by workers' compensation boards. Those that did tended to view them with mixed feelings. In some instances, the consultants helped connect treating health-care providers with the workers' compensation board. There were instances when health-care providers spoke with consultants and were able to communicate in the "same language" and not have to explain medical terminology. This made discussions more fruitful and efficient. There were health-care providers, in British Columbia and Manitoba predominantly, who used internal medical consultants as a resource – to find out about entitlements or fundable treatment options, for example. Other health-care providers, however, were critical of the use of internal medical consultants by workers' compensation boards. In part this was due to the perception that internal consultants reviewed claim files and medical charts and made decisions on the basis of these "paper reviews" without actually seeing the patient.

Interviewed internal medical consultants did say that much of their work entailed chart reviews but that they also sometimes physically examined patients when necessary. As was noted earlier, health-care providers became frustrated when their medical recommendations were overturned by case managers or internal medical consultants, particularly when these individuals had never seen the patient and did not know his or her history:

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 workers' compensation board trumps, even, multiple care providers sharing the same concern. That's been my experience. – P#62, health-care provider-specialist, MB

While many case managers stressed that internal medical consultants were not the ones who made decisions on a claim, their opinion seemed to matter a great deal. For example, one case manager explained:

I would also add that they are unbelievably key to what we do. I cannot make a decision on the entitlement to benefits without input from a WCB medical advisor, chiropractic advisor, physio advisor, psychological advisor, it goes on and on. I need their input because that's not what I do for a living. I'm not a doctor, I'm not any of those things. I need their input in order to move forward and 99.999 per cent of the time, I will go—assuming it's a good opinion—I will go with their opinion. They are a key, they are paramount to what we do, vitally important. – P#63, case manager, MB

A number of health-care providers were concerned that internal medical consultants, given that they were located at and paid by the workers' compensation board, were not independent, and having them provide opinions related to work-relatedness, treatment or benefit entitlement was problematic. Some health-care providers believed that case managers may cherry pick opinions offered by internal consultants, choosing those that were favourable to the workers' compensation board (for example, ones that reduced costs):

I think there should be a policy where WCB takes the recommendations of the treating clinicians and not rely on the recommendations of the medical advisors who work for the WCB. I believe there's a conflict of interest in relying only on the medical advisors who work for the WCB in terms of approving funding for treatments that WCB has to pay for. – P#76, health-care provider specialist, MB

While case managers were clearly able to articulate the benefits of independent medical consultants to their decision-making, health-care providers who had their opinions disregarded or overturned became further alienated from the workers' compensation system and the RTW process.

Alienation of health-care providers also occurred due to some of the funding and reimbursement structures present at the workers' compensation boards. While most physicians were generally satisfied with the amount of reimbursement received for services and form completion from the workers' compensation boards for straightforward claims, it was noted that reimbursement amounts were not always adequate when claims became complex. Health-care providers explained that there was no reimbursement for initiating contact with the workers' compensation boards or the employer or for extensive RTW planning. As claims became more complicated and prolonged, health-care providers needed to spend more time reviewing files and filling out forms. These activities, if they took place, were often done pro-bono. Allied health-care providers such as physiotherapists, occupational therapists, psychologists and chiropractors also listed a number of financial disincentives for treating workers' compensation patients:

WorkSafeBC will only reimburse us \$23 which doesn't make it possible for us to even cover the overhead of us being there. So what happens is, if you accept WorkSafeBC [patients], you'd be inundated with it. So we had one [allied health-care provider] in our area who accepted WorkSafeBC, and he ended up almost not being able to cover his overhead as a therapist.... With the influx of WorkSafeBC patients, it isn't sustainable, the reimbursement. Or, the alternative to that is the therapist will pro-rate their time to make it so that they can cover their overhead, but that means that they may only have five minutes to work with that patient, which isn't sufficient enough time to provide a quality treatment, and I won't sacrifice my quality in that way. But that's what happens to people, so the compensation through the WorkSafe program for a [allied health-care provider] isn't working out and is a real barrier to care for people. – P#109, health-care provider-allied, BC

That's a problem in community therapy too, is a lot of therapists choose not to see WorkSafe clients because the pay is so low. And whereas in programs like this, they pay per program, so it's more employees so it's different... but I would say, as far as from my community therapy side, I would say actually, no. As far as the forms [payment], yes, that's okay, but as far as seeing the client, you don't make that much money, seeing them. It's actually better to see a private or an ICBC (Insurance Corporation of British Columbia) client. – P#119, health-care provider-allied, BC

In Ontario, one allied health-care provider described how certain reimbursement structures affected practitioners, particularly in community settings (as opposed to in clinics funded by workers' compensation boards or in hospitals):

Before they would allow for 12 weeks, and now they're allowing for eight weeks ... the expectation is essentially for a faster recovery.... Essentially when you bill out, if your patient has not returned to work fully, by the time of your eight-week protocol, you get paid differently. It doesn't matter how often you've seen them, or what care you've provided but you get paid less if they don't do well. So, it's almost like they're faulting you, even though it's just your patient's progression. In fact you have probably poured out more time and more visits with someone who is struggling, than someone who is progressing really well, so I find that very kind of discouraging. And I feel like in this setting, within the hospital setting, we aren't really affected by that, but I could see someone in private practice being really affected by that. – P#109, health-care provider-allied, ON

As was suggested by a number of allied health-care providers, reimbursement structures at the workers' compensation boards sometimes had an impact on the quality and frequency of care that injured workers received. Financial disincentives could make it difficult for allied health-care providers to treat injured workers, particularly in the community, deterring community-based allied health-care providers from seeing workers' compensation clients and being involved in the RTW process.

Challenge 6: Issues related to the broader health-care system

A number of case managers and health-care providers described how broader issues affecting patients' access to health-care services affected the RTW process. Participants noted that many injured workers, particularly in northern and remote communities, did not have family doctors. As a result, these patients depended on walk-in clinics or emergency rooms as their primary source of health care. This situation was especially problematic for workers with complex conditions. Health-care providers who worked in emergency rooms said that sometimes employers sent injured workers to walk-in clinics or emergency rooms in order to get forms filled in quickly. Treating workers' compensation patients in walk-in clinics and emergency rooms was challenging; managing the RTW process, even more so. As one health-care provider noted, forms that injured workers had to submit were not always filled in correctly in these settings:

Patients with work-related injuries who are required to get forms completed, which they are told are fairly urgent in nature, although the condition itself would not be considered urgent or in need of urgent care. But, at issue is the form taking precedence over what would be deemed a non-urgent medical problem. It makes it difficult because it tends to drive patients into, as I say, walk-in clinics where they are not seen by their primary care physician, they're seen by another physician who doesn't necessarily have the desire to do an examination that is sufficient for a first report. – P#7, health-care provider, ON

Two health-care providers, both from Ontario, described their frustrations at seeing non-acute patients in the emergency room:

The most challenging part is that currently I'm not a full-time continuity of care providing doc. I do all the stuff when I see patients and then don't see them again often. And, so the hardest part is when I get paperwork back because then it wastes more time tracking down the patient and trying to follow up than I ever spent seeing the patient in the first place. And, so in that sense I could literally spend \$300 worth of time trying to track down a patient that I got paid \$30 to see plus the \$85 form or whatever. That's not good. And, many patients, while it's nice to say follow up with your family doctor, and it would be nice if that was a default follow up place, a lot of patients I see don't have a family doctor. – P#25, health-care provider, ON

The most recent one I can think of is probably 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.... But we deal with a lot of long-term issues, but they're not appropriate in the emergency department, that's my frustration. – P#28, health-care provider, ON

When injured workers went to emergency rooms or walk-in clinics for treatment, there was little continuity of care. The doctor treating them did not know their previous medical history and were unlikely to see them again if the patient returned for a follow-up visit. This made the workers' compensation process more challenging.

A number of health-care providers and case managers also discussed how wait times for tests and specialist appointments sometimes delayed RTW. Some health-care providers were aware that injured workers could sometimes be sent for tests or

to see specialists without long wait times (for instance, via specialty clinics) while others discussed the challenges of keeping a patient progressing toward recovery and RTW given long delays:

Sometimes you don't have the accessibility to diagnostics such as MRIs, CT scans, in a timely fashion. So that's sometimes, within the health-care community, that's a challenge for physicians when it comes to return to work because they're trying to properly diagnose and make treatment recommendations. But if you don't have that accessibility to resources to properly diagnose your patient, or if your patient is communicating symptoms or issues that don't seem to be consistent, there is more caution there because without the proper diagnosis, physicians don't want to make a mistake. – P#33, case manager, ON

Factors such as long delays or seeing injured workers at walk-in clinics or emergency rooms typically made the RTW process more difficult. When forms were not filled in correctly, when there were long delays in getting needed tests or breaks in the continuity of care, this led to difficulties for both the injured workers and health-care providers.

Discussion and Recommendations

What can help engage health-care providers in the workers' compensation and RTW process?

This study raises a number of important questions regarding the role of health-care providers in the workers' compensation process and RTW. We began this study with the presumption that the role of health-care providers in RTW should be enhanced and with the goal of investigating how greater engagement and involvement could be achieved. However, it quickly became clear that there was a significant amount of disagreement and confusion about what the role of health-care providers should be in the RTW process and in the workers' compensation system more generally. We recommend that workers' compensation policy-makers, health-care providers, along with other stakeholders (e.g. injured workers, employers, unions), engage in a dialogue to identify clear guidelines related to the role of health-care providers in the workers' compensation and RTW process. Ideally, this dialogue will lead to a

consensus. Guidelines should acknowledge that health-care providers have different levels of capacity for RTW planning and other activities such as conducting functional assessments. The question of what role health-care providers should play in RTW and in the workers' compensation process is a challenging one.

Based on the study findings, the following are possibilities for the role of health-care providers:

- 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 that may complicate recovery and RTW
- Identifying chronic pain or deterioration in mental health
- Communicating with the workers' compensation board about further treatment needs (e.g. counselling, occupational therapy, etc.)

Certain allied health-care providers and occupational medicine specialists may be 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. General practitioners who have not had training in the area of occupational health or disability management and do not understand how the workers' compensation system functions are likely to struggle with this role.

However, as we have stated above, what is needed is a comprehensive discussion and consensus among workers' compensation stakeholders about health-care providers' appropriate roles.

Beyond divergent views about roles in the RTW process, this study suggests that case managers and health-care providers may have different views on RTW itself. While health-care providers recognized that RTW is important, they suggested there were instances when early RTW was not appropriate. Many health-care providers described instances when they felt that early RTW might ultimately delay recovery and have a negative impact on long-term RTW outcomes. Issues such as pain were viewed by some health-care providers as reasons to delay RTW. In the last several years, critiques have emerged about the stance of workers' compensation decision-makers that early RTW is (virtually) always indicated and that pain is not an appropriate reason to delay RTW (Reid et al, 1991; Beaton, 2000; Carroll et al, 2012; MacEachen et al, 2007). Such views seemed to resonate with many health-care

providers who recognized that some patients will require time off work to recover and that there is a need to consider individual factors (e.g. co-morbid conditions, mental health, pain, etc.) and work-related circumstances (e.g. the removal of the cause of injury, appropriately accommodated work, etc.).

Every worker comes to the workers' compensation board with a particular medical history, and many will have conditions, both psychological and physical, that may be exacerbated by work injuries or may delay the RTW process. The treating health-care provider (typically the family physician) is often in a better position than a case manager to understand the factors that will complicate recovery and RTW. This type of insight should not be ignored or used to deny benefits. Rather, it should be thoughtfully integrated into treatment and RTW planning. There is a need for workers' compensation decision-makers to consider the views of treating health-care providers when it comes to appropriateness of RTW, particularly in complicated cases.

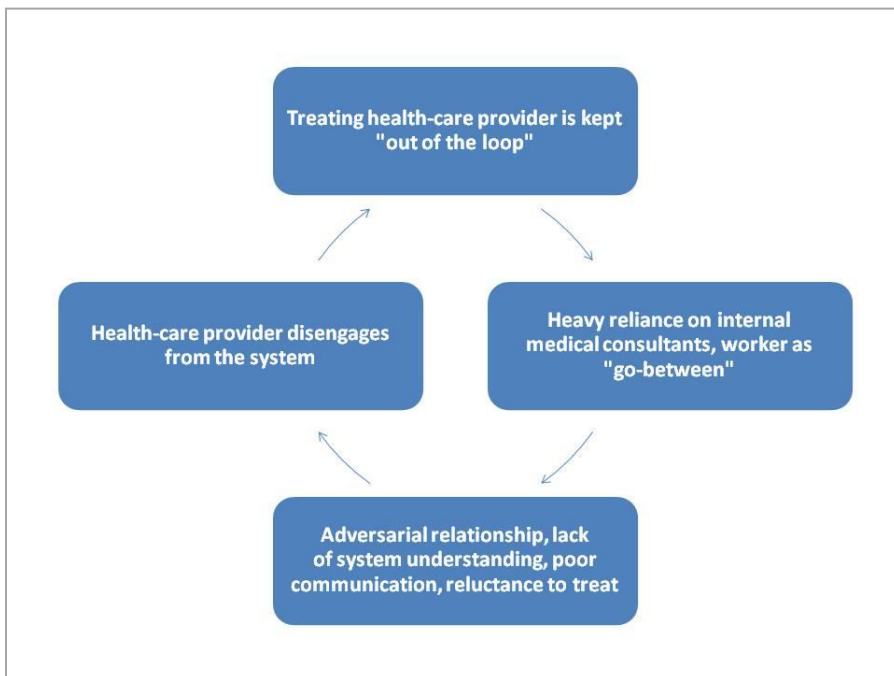
In this study, health-care providers described how complicated conditions lacking "objective" evidence often did not "fit" into the processes and procedures in place at the workers' compensation boards (Horppu et al, 2016). The result for injured workers with these conditions was repeated treatment interruptions, appeals and stigmatization. Workers' compensation boards should consider how to fairly and quickly adjudicate complex, multi-causal and gradual on-set conditions in a way that does not further injure and stigmatize workers. This may involve more specialized training for case managers on mental health care and complex conditions.

Seing and MacEachen (2015), in their study of disability management practices, discussed the need for flexibility, rather than procedural correctness, when it comes to dealing with RTW situations. Similarly, a number of health-care providers in this study felt that workers' compensation boards need a more flexible approach when it comes to dealing with complex and prolonged claims. When a worker's recovery is not aligned with published recovery guidelines, this may be an opportunity to offer additional resources to that worker and health-care provider (rather than responding in a punitive way by ceasing treatment or benefits). In part, "flexibility" might mean designing forms that are adaptable to complex medical issues and difficult RTW situations. A recognition that recovery trajectories vary may be particularly important when it comes to multi-causal, gradual onset and "invisible" conditions. In these

circumstances, it is important to work with the treating health-care professional to determine what factors may hinder or facilitate recovery and RTW.

While the scientific literature on RTW has a focus on collaboration and enhanced health-care provider involvement in RTW, we found many factors that alienated health-care providers from the workers' compensation process. A lack of system-related information, discordant communication practices and a heavy reliance on internal medical consultants are some practices that may lead to health-care provider disengagement from the workers' compensation system or, worse, a refusal to treat workers' compensation patients. The diagram below describes how we saw a potential cycle of alienation develop during interactions between health-care providers and workers' compensation decision-makers.

Figure A



While internal medical consultants are an important part of the workers' compensation system, their use in decision-making could also alienate the treating health-care provider. When treating health professionals feel like their opinion does not matter, and this is coupled with an unclear understanding of their role or the workers' compensation system, a lack of engagement is not surprising. However, when health-care providers do not fill in forms correctly, do not provide adequate

information or do not return calls, case managers need the expertise of internal medical consultants to make timely decisions. One recommendation is to investigate and work to rectify conditions that may impede meaningful participation of health-care providers. For example, forms may not be filled in correctly or completely because they are not well-suited to describing complicated and difficult situations. Calls may not be returned when health-care providers only have access to a general workers' compensation board number or do not know how to reach someone with medical training.

Another recommendation is to give the treating health-care provider a number of opportunities to participate in the process and, if these attempts are not successful, to then turn to the independent medical consultant. In British Columbia, for example, health-care providers can tick a box on their form to indicate that they would like support with RTW, and this initiates a call from the case manager or independent medical consultant. As we found in this study, health-care providers in emergency rooms or walk-in clinics may not feel well-equipped to manage RTW, and it is important for them to communicate the need for support (or a complete transfer of responsibility for RTW) efficiently and directly. Importantly, a greater transparency of the process is needed, including what role independent medical consultants play and why they are used in decision-making. There is some promise in the stories of collaboration, particularly in Manitoba and British Columbia, between treating health-care providers and independent medical consultants. As described by some participants, independent medical consultants can have open discussions with treating health-care providers about treatment options and RTW, and these can sometimes lead to better outcomes for injured workers.

A number of practical issues can also help build collaborative interactions between health-care providers and workers' compensation boards. Messaging around health-care provider role and RTW involvement should be consistent across materials and clearly outlined. Most workers' compensation boards have a section on their website aimed at health-care providers, and this area could be used to clearly define agreed-upon roles, provide information about what to do if a problem is encountered, and identify individuals to contact if the health-care provider requires assistance. This area can also have a section clearly describing how the workers' compensation system operates, systemic requirements (regarding reporting, for example), information about who makes decisions, and so on. While not every health-care

provider will want to have a comprehensive understanding of the workers' compensation system, the information should be readily available for those who do. Further, a secure central portal or repository that can house treatment notes, recommendations and case manager decisions would allow each health-care provider involved in the care of injured workers to view information pertaining to his or her patient. This would also help make decision-making more transparent.

Beyond providing information on workers' compensation board websites, participants had a number of other suggestions about how to get information to health-care providers. These included: linking with medical schools to provide educational sessions to general practice residents focused on workers' compensation and RTW; involving internal medical consultants in outreach activities to other physicians; holding WCB-sponsored conferences and conference presentations; offering webinars and short courses for continuing medical education credits; and developing electronic applications for mobile devices. Participants suggested that training and courses should be customized; i.e. the content should vary depending on whether it is being delivered to general practitioners, occupational health physicians or emergency room physicians. There is a need to provide resources and information in a variety of formats and at different points of a health-care provider's career.

Study Limitations and Strengths

This was a large qualitative study in four provinces, and we were able to gain valuable information from health-care providers who had different levels of involvement with workers' compensation and RTW. In-depth, semi-structured interviews elicited rich data about how different health-care providers managed work-related injuries, their rationale for particular approaches, their views and beliefs. As part of the study, we were also able to access case managers who provided us with insight into their jobs and into how they use medical evidence. Interviewing both health-care providers and case managers in Manitoba and British Columbia allowed us to understand more clearly how and why certain dynamics develop and how these two key workers' compensation stakeholders interact.

Unfortunately, we did not gain permission to interview case managers (or independent medical consultants) in Ontario and Newfoundland and Labrador, and

this is a shortcoming of the study. We also did not interview injured workers or employers, who interact with health-care providers and may have different perspectives about the role of health-care providers in RTW.

As with all qualitative studies, this research does not tell us about the prevalence of particular events or about the percentage of health-care providers experiencing certain problems. Rather, the study provides insight into why and how certain situations and difficulties can develop. The fact that many of the themes discussed in this report were repeated across jurisdictions and by different types of health-care providers lends confidence to our findings.

Conclusion

Return to work can be an important part of recovery. Most health-care providers in this study were supportive of efforts to return their patients to work after injury or illness. When injuries were visible, straightforward and acute, this process was often not problematic. Yet, health-care providers encountered difficulties when patients had complex conditions and claims became prolonged. This study suggests ways in which health-care providers can become removed and alienated from the workers' compensation and RTW process, a process that has a profound impact on their patients. Systemic and procedural changes are needed to address issues that arise when health-care providers treat workers with complex injuries and interact with the workers' compensation board during these claims. These include measures to increase flexibility, incorporate knowledge about complex conditions into decision-making, and reduce barriers to effective collaboration.

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