NEWFOUNDLAND AND LABRADOR HEALTH BOARDS ASSOCIATION

SUBMISSION TO THE WORKERS' COMPENSATION STATUTORY REVIEW COMMITTEE JANUARY 2006

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Submitted by

Newfoundland and Labrador Health Boards Association

on behalf of:

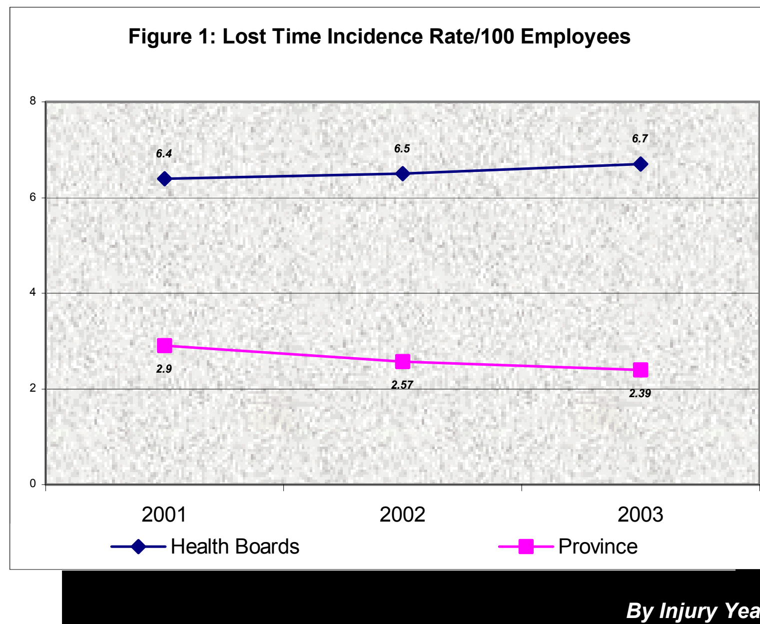
- Central Health
- Eastern Health
- Labrador-Grenfell Health
- Western Health

Workers' Compensation 2006 Statutory Review: Introduction

The Newfoundland and Labrador Health Boards Association (NLHBA) is the federation of Regional Health Authorities (RHA) that serve Newfoundlanders and Labradorians across the province. The Boards of the RHAs are governed by voluntary trustees who are appointed by the Minister of Health and Community Services and serve without payment in the public interest.

The NLHBA and its member organizations are pleased to have the opportunity to provide input into the current statutory review of the workers' compensation system in Newfoundland and Labrador. In anticipation of the statutory review, a working group of member organizations was formed to bring a collective voice to the concerns faced by the health care sector.

The Health Authorities in this province are committed to working with the Workplace Health, Safety and Compensation Commission to address issues of mutual concern and priority. Since the last statutory review, all health care organizations have put additional programs and resources in place to improve the safety of our employees and to ensure early and safe return to work in the event of an occupational illness or injury. According to WHSCC statistics as illustrated in Figure 1, inroads have been made into reducing the lost time incident rate provincially; however, indicators from the health care organizations remain significantly higher than the provincial rates.



Source: HHR Indicator Report 1999 to 2003 Department of Health and Community Services.

When analyzed further, injury statistics for the health and social services sector demonstrate the predominance of sprain/strain injuries (72% of lost time injuries in 2003 compared to the provincial indicator of 59% of lost time injuries). Claims cost data for the Health and Social Services Sector have also not shown any dramatic improvements since the introduction of the last round of legislative amendments. According to WHSCC data, sector claims costs were $15.3 million in 1999 and $14.8 million in 2003. Therefore, despite being designated under the WHSCC's priority employer program and

although significant time and resources have being invested by the Commission and the health organizations, no dramatic gains have been made.

While complete data is unavailable from the health organizations before 2001, data from 2001-2002 and 2002-2003 fiscal years do indicate a reduction in lost time hours per employee from 40.2 hours to 33.7 hours. This does suggest that claims' duration may have been impacted positively by the introduction of the early and safe return to work legislation.

This submission represents the views and opinions of the Health Authorities while recognizing there are unique regional and operational concerns, which also exist from region to region. The Health Authorities feel the WHSCC should consider the following when developing plans for the upcoming five years:

- Improving strategic partnerships with health care and investing in evidence-based initiatives and programming aimed at reducing the lost time incident rate
- Investing in more seamless claims' administration and adjudication.
- Reducing claims' duration through improved medical management and accountability of health care providers.
- Applying flexibility to the implementation of PRIME

The NLHBA and its member organizations remain committed to working with the WHSCC and its other partners in addressing these problems in a cooperative and strategic manner.

Strategic Partnerships

The NLHBA and its member organizations are interested in developing a proactive strategy toward the health and safety of health care employees across the province. The provincial Healthy Workplace Initiative, which is jointly funded by the NLHBA, its members and Health Canada, is an example of one such initiative, which is aimed at creating a shift in the safety culture in health care. The NLHBA is encouraged by WHSCC's presence on the steering committee for this project; however, feels that the WHSCC should become a formal partner with the organizations and Health Canada in this initiative.

After the last statutory review, the WHSCC allocated a significant amount of money to the Federation of Labour to support the training of union representatives, employees and some employers in Early and Safe Return to Work. While it is recognized that there was value in training workers on this topic, the health organizations have significant concerns about the amount of money spent, and continuing to be spent, on this initiative with what appears to be limited consideration for the significant needs elsewhere in the health care system.

In addition, the NLHBA commends the WHSCC's commitment to the delivery of occupational health and safety training targeted at managers and occupational health and safety committees. However, the NLHBA would like to know if the WHSCC has completed an analysis of the return the commission has received on these investments.

One health organization in particular reported concerns with being able to access the occupational health and safety workshops without having to incur additional cost to fund travel to major centers in the province.

The NLHBA would encourage the WHSCC to consider these investments from a cost benefit perspective and to canvass employers for their strategic training needs before decisions of this nature are made in the future. WHSCC should recognize that the funding for such initiatives comes from employers; therefore, formal input should be sought.

Section 20.5 of the *Workplace Health, Safety and Compensation Act* indicates that the Commission shall allocate up to 2% of its total assessment and investment income each calendar year into a research fund which is geared toward health and safety research. Given that the Health and Social Services sector exceeds the provincial percentage for soft tissue injuries (72% versus 59%) and, as indicated earlier, the health organizations far exceed the province in lost time rates, the commission should take a proactive approach in partnering with health care employers to conduct research in our highest risk areas.[1]

This approach has been successful in other provinces and has lead to an investment in new technologies and work practices that have improved safety for health care workers. The province of British Columbia, for example, has worked closely with health care in identifying key safety hazards and has developed a strategic response to each.

British Columbia's HealthCare Projects Forum in 2002 invested in a number of valuable projects in the areas of:

- Ergonomics and MSI (musculoskeletal injuries)
- Aggression and violence
- Bloodborne pathogens
- Chemical exposures
- Ceiling lifts
- Mechanized laundry/linen collection
- Early return to work

These investments seem to bear out in terms of positive returns in the sector with the total number of short-term disability claims falling from 8,474 in 2002 to 6,244 in 2004 - a 26% reduction! Health care organizations in that province have been rewarded with reductions in assessment rates – dropping in acute care from $2.71 in 2000 to $1.64 in 2005 and dropping in long term care from $4.25 in 2000 to $2.96 in 2005.[2] The NLHBA invites WHSCC to become a formal partner in the development and funding of similar strategic initiatives.

[1] Based on 2003 WHSCC data.
[2] www.worksafebc.ca

Claims Adjudication and Administration

The responsible and efficient interpretation, adjudication and administration of the *Workplace Health, Safety and Compensation Act* are key to controlling claims costs and durations. Based on the collective experience of the health care organizations, the following recommendations are made related to the various sections of the Act and accompanying policy.

Section 43 – Compensation Payable

Health care employers have growing concerns about the number of claims that have been accepted for workers with health problems classified as "environmental sensitivities". For example, we have had workers with allergies to scented products, dust and flowers, all of which have been accepted by the commission. We feel that these illnesses should be recognized as pre-existing conditions in almost all cases (and as such should be proportioned) since it is rarely the workplace that was the cause of the allergy developing. Acceptance of claims for allergies should be evidence-based and as such should be well researched to determine if the industry was a contributing factor in the development of the condition.

In addition, the commission should review the practices from other workers' compensation boards. Health care employers question the commission's practice of paying compensation beyond the acute phase of the illness. In a number of cases, workers continue to receive compensation despite reaching a medical plateau in their condition. These cases should be proportioned or sent for a labour market re-entry (LMR) assessment at this point in the claim. Instead the practice has been to continue to pay lost time benefits to the worker as a means of preventing a flare up of the sensitivity or allergy.

Section 43.1 – Proportionate Compensation

This section states that, in cases in which there is a pre-existing condition, compensation is payable for the proportion of the loss of earnings or permanent impairment that the commission determines is attributable to the injury. Based on the current experience of the health care organizations in this province, it appears that the Commission is applying this section of the Act at the point at which the worker is moving to the labour market re-entry (LMR) or extended earnings loss (EEL) phase of the claim.

It is recommended that the Commission advise the worker of the potential for proportionment at the outset of the claim and that the proportionment of compensation take effect after the normal recovery period for the type of injury. These normal recovery times should be based on benchmarks such as are found in Presley Reid's "Medical Disability Advisor" and may also consider any undue delays that the worker may experience in receiving medical intervention which are not attributable to the pre-existing condition.

Section 53. (1) – Notice of Accident

This section states “compensation is not payable to a worker unless…(a) he or she, or another person on behalf of the worker, gives notice of the injury to his or her employer *immediately after the occurrence* of the injury and before he or she has voluntarily left the employment in which he or she was injured….”. Based on our collective experience, there have been many occasions in which workers have not reported their injury to an agent of the employer (i.e. manager, supervisor, human resources). This is indicated to the commission on the Form 7 as “No incident report received”. This should be given weight by the intake adjudicator because this failure to report appropriately does prejudice the employer in that it cannot conduct an appropriate accident investigation.

Section 54.1 - Mitigation of Injury

This section outlines the worker’s responsibilities in the event of an injury. It is recommended that this section include a responsibility for the worker to communicate with the employer on a regular basis and report to the employer any changes in circumstances that affect or may affect the worker’s entitlement to benefits.

Section 59 - Claim Investigated

This section indicates that the commission will investigate and process a claim “…at the earliest convenient date.” It is recommended that this wording be replaced with a specific time frame, as the current wording is very broad. Based on our collective experience, there can at times be significant delays in having claims adjudicated. This can lead to delays in medical intervention and can also cause over/under payment situations, which increase the administrative burden to the employer as we have a direct pay system for our injured workers.

Section 80 – Calculation of Earnings

Currently the commission requires employers to provide earnings’ information for the past four pay periods prior to the date of injury and, if the claim exceeds 13 weeks in duration, the employer is asked to provide 12 months’ of earnings. It is recommended that the commission base all compensation on 12 months of earnings from the outset of the claim. This would eliminate duplication of effort for both the employer and the WHSCC.

In addition, retroactive payments to the worker should only be included in the reportable earnings if they are tagged to the same 12-month period. Retroactive payments for periods prior to the 12-month earnings should not be included in the calculation of earnings for the worker. For example, a worker may receive retroactive pay for a pay increase that occurred in 2003 but was paid out in 2005. The portion of the pay increase that was paid in 2003 and 2004 should not be included as earnings even though they were paid in 2005.

Section 89.2 – Labour Market Re-entry (LMR) Assessment and Plan

This section identifies the criteria by which the commission will determine if an individual should be referred for a labour market re-entry (LMR) assessment. Health care employers have a number of concerns related to the LMR process. Firstly, the commission should ensure that the private LMR providers have the appropriate credentials and the outcomes of these services should be monitored and evaluated on a regular basis. Secondly, health care employers would also like to see time frames incorporated into this section, which specify how long the provider has to complete the required work and make final recommendations. It has been our experience that some LMR assessments have been unduly delayed, thereby, increasing claims' duration and costs. Thirdly, the commission should consider early evaluation of retraining options while a person is still in the medical rehab phase as this may avoid unnecessary delays down the road. If retraining options are identified early, the injured worker may be expected to pursue skills upgrading (especially GED) concurrent with the medical rehab phase of the injury. Fourthly, the LMR providers should consult with employers during the LMR phase to identify possible cost-effective retraining strategies, which would allow the employee to remain with the original employer. Finally, there should be no delays on the commission's part in making a referral for a labour market re-entry assessment.

Medical Management

The health care organizations recognize and accept their role and responsibilities related to prevention and early and safe return to work. At the same time, the health organizations feel the WHSCC must recognize that the reduction of claims' duration hinges on good medical management, access to appropriate health care services in a timely manner and the accountability of health care providers.

Despite the organizations' best efforts in trying to expedite return to work programs for health care employees in the safest and most timely manner possible, external factors invariably contribute to delays in the process. The health organizations welcome any initiatives that are aimed at the provision of objective and timely information, which supports the return to work process. Despite the introduction of the Functional Abilities Form 8/10, employers are still missing valuable information, which would lead to an earlier return to work. Many times, physicians provide 8/10s with subjective reports of "too much pain" or "not capable of work at this time." The health organizations recommend that the WHSCC should not pay for 8/10s, which are solely based on the employee's subjective reports of pain. It is also recommended that "Not capable of work at this time" be removed from the Form 8/10.

The NLHBA feels that it is time for the commission to objectively identify the outliers amongst health care providers and to develop a strategy to bring them in line with acceptable standards. In doing so, the commission should not only target physicians, but also rehabilitation professionals such as occupational therapists and physiotherapists.

The WHSCC should place more weight on objective functional evidence over pure medical opinion. Allowing physiotherapists or occupational therapist input into the claim via the Form 8/10 may provide for a more balanced view of the injury.

The NLHBA would also like to express concern related to the recently adopted EMPOWER program. While the principle behind the program appears to follow best practice related to early intervention, the health organizations have some pragmatic issues:

- No consultation was done with employers prior to the introduction of the program. In addition, the health organizations recall limited, if any notice being given on the introduction of the program. The health organizations had similar concerns about previously introduced early intervention programs.
- Representatives from the health organizations report a significant disconnect with the clinic(s) responsible for the program. Often the employer is not advised of the case conference time or date or is notified only a day or two ahead of time, making it impossible to accommodate for scheduling reasons. Health organizations are interested in being an equal contributor to the case conference sessions; however, our voice is often not at the table.
- The spirit of the program is early intervention; however, several health care employees have been more than six months on a TEL claims before they have been referred to the program. In addition, scheduling problems have led to significant delays in the employee's case being conferenced and a final outcome delivered.
- The outcomes of the program must be reviewed. Most health care organizations report that EMPOWER referrals end with an outcome of an occupational therapy referral. The health care organizations question the need for a lengthy and expensive EMPOWER program which results in the same result for the majority of participants. This is particularly true in health care given that most of the organizations have established internal and/or external occupational therapy resources, which could intervene more quickly.

PRIME implementation

Policy PR-06 – PRIME Practice Incentive for Provincially Regulated Employers

While in theory, health care organizations agree that the PRIME practice incentive should be met; there is concern about the time frame in which employers have been given to comply with these criteria. While broad information was made available on the five practice criteria, the detailed information that is now contained in the PRIME audit tool has only been made available in the Fall of 2005 leaving employers with only a few months to ensure that their programs are structured and documented in a way that will satisfy the WHSCC audit requirements.

There is also concern about the changing interpretations of specific provisions of the PRIME practice criteria. One such example is the completion of workplace inspections. Until November 2005, health care employers were assured by commission staff that the requirement would be to show evidence that an inspection was completed in two areas of the organization. In mid-November, this interpretation changed to mean two full inspections of the entire site. This late interpretation change left health care employers

frustrated and concerned about losing potential refunds that could have been earmarked toward safety.

In addition, health care is currently undergoing a significant restructuring initiative, which has directed resources and attention to that effort. The commission should allow some consideration and flexibility when auditing the health care organizations in 2006. The commission is expecting 100% compliance with all audit criteria; however, we feel that if we can demonstrate that the majority of work is completed and in place (even if it may not be exactly in the format required by the audit) some flexibility should be allowed.

In relation to the experience incentive portion of PRIME, there is significant concern that a good portion of the responsibility for our claims' costs rests with the commission itself. Health care employers have experienced undue delays in relation to the adjudication and medical management of lost time claims over which there has been little or no control by the employer itself. For example, there is currently a five to six week delay for workers being seen in the EMPOWER program and then up to a two to three month wait for the case to be conferenced. In addition, we have been notified that access to an orthopedic specialist has been limited and, given that the majority of our cases are musculoskeletal injuries, this will cause additional delays. Health care employers would like to work much more closely with the commission in establishing a better claims management process and the commission should consider investing more resources on the case management side to allow for more efficient claims processing.

Additional Recommendations

In addition to the legislative recommendations highlighted above, the health organizations would like to make the following recommendations:

1. The Commission decision makers should attend workers' compensation review division hearings to defend the commission's official position. Often health care employers feel they assume this responsibility in review division hearings.
2. Health care organizations find WCRD hearings to be unbalanced in terms of time allocated to the presenters. In most cases, the worker representative consumes the majority of the hearing time. This situation should be reviewed and consideration given to a better formal balance of presentation time.
3. The Commission should investigate alternate dispute settlement options such as expedited mediation if, *and only if*, the outcome is binding on all parties and if the process replaces the option to move to a WCRD hearing. This alternate process could be offered as a voluntary process.
4. The Commission should review the mandate of the Ergonomist position and, if necessary, expand the resources dedicated to this area. This recommendation is made in recognition of the high incidence of musculoskeletal sprain strain injuries being experienced in the health care sector.
5. Training initiatives should be outsourced when necessary to a neutral third party provider. The health organizations feel that labour and employer groups have other vested interests that may cloud the objectivity of the information being provided.
6. The Commission should continue with the planned implementation of its e-strategy aimed at reducing administration time and costs. However, the health

organizations would caution against automated approval of claims, recognizing the value and the need for appropriate investigative adjudication of claims.

7. The health care organizations are not in favour of the introduction of a waiting period for lost time claims despite the potential financial savings. It is felt that this would lead to underreporting of claims and compromise the development of a responsive occupational health and safety program.
8. At the same time, the health organizations would not support an increase in benefit levels for injured workers until such time that the long term financial viability of the system is secured.
9. Given that health care is one of the more hazardous industries, given the complexity of injuries and return to work in this industry and given the significant dollars that health care contributes to the administration of the WHSCC, health care organizations feel there is merit to allocating one position on the Commission's Board of Directors to a representative from the health care industry.
10. Health care organizations outside the St. John's region have concerns that the adjudicators are being removed from the region. It is felt that having a local adjudicator makes for a good working relationship with the Commission in that the adjudicator is more familiar with the health care organization and the nature of the work performed in the region.