HOSPITAL EMPLOYEES' UNION

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July 19, 2019

Janet Patterson
Workers' Compensation Review

By email: info@wcbreview.ca

Dear Ms. Patterson:

HEU Workers' Compensation Review Submission

Please accept the attached submission from the Hospital Employees' Union.

Thank you for the opportunity to participate in this process.

Sincerely,

Jennifer Whiteside
Secretary-Business Manager

attachment

Hospital Employees' Union:
Workers' Compensation Review Submission

The Hospital Employees' Union (HEU) is the oldest and largest health care union in British Columbia, representing more than 50,000 members working for public, non-profit and private employers. HEU is also the B.C. health care services division of the Canadian Union of Public Employees (CUPE), making HEU part of the biggest union in Canada.

HEU is a racially diverse, predominantly female union. Eighty-five per cent of our members are women, who work in all areas of the health system – acute care hospitals, residential care facilities, community group homes, outpatient clinics and medical labs, community social services, and First Nations health agencies – providing both direct and non-direct care services.

We thank the Minister of Labour Harry Bains for introducing a review of the workers' compensation system, and for acknowledging that the system must take a worker-centered approach. We also appreciate this opportunity to provide an account of how the current system has failed many HEU members and our recommendations for improvements. Without question, the workers' compensation system is long overdue for change.

INJURIES IN HEALTH CARE

According to the Workers' Compensation Board (WCB) 2018 statistics, health care workers have the highest injury rate of any sector in the province. And health care assistants have the highest rate of workplace violence injuries of any occupational group in B.C.

In 2018, the B.C. provincial injury rate was 2.2. The health care sector injury rate was 3.6, almost twice the provincial average. And when reviewing the subsectors within health care, the acute care injury rate was above the health care sector injury rate at 4.2 in 2018, up slightly from 4.0 in 2017. The long-term care injury rate in 2018 was 8.0, down slightly from 8.9 in 2017, but still close to four times the provincial average.

HEU also represents 4,600 health care workers, who provide support services in hospitals and long-term care facilities. They are employed by Compass, Sodexo, Marquise, Aramark and Acciona. These workers work primarily in housekeeping and dietary, two occupational groups that have a high injury rate. As a result of the privatization, this work is not included in the WCB health care subsector; rather, the employers' classification unit is the hospitality subsector. Consequently, the WCB health care subsector statistics do not reflect the injury and claims experience of the entire health care system in B.C.

Musculoskeletal injuries (MSIs), physical and psychological injury from violence on the job, and falls are the three major injuries in health care for claims filed. In long-term care, the three occupations with the most injuries and illnesses are nurses' aides at 64.8 per cent, LPNs at 10.8 per cent, and RNs at 4.5 per cent. In acute care occupations, those with the most injuries and illnesses were RNs at 35.2 per cent, nurses' aides at 18.7 per cent, and LPNs at 12.8 per cent.

THE COST OF WORKPLACE INJURIES

The cost of workplace injuries and illnesses have been astronomical. The number of work days lost in 2018 in the health sector combined was 426,920 days. Claims amounts in the health care sector were $107, 254,000 in 2018, alone.

For our HEU members, who have been injured on the job, it may be years before they return to work, or they may not be able to work at all. They may also experience severely reduced incomes, increased anxiety, depression, and psychological trauma, family difficulties, and even poverty.

Clearly, the current situation must change. The exceptionally high injury rate in health care is not acceptable. The compensation levels are not adequate. And our members' experiences accessing the services they need to receive compensation and return to work are challenging.

We also know that the injury rates cited here are but the tip of the iceberg. Statistics do not tell the whole story. These numbers only reflect accepted claims and do not account for under-reporting or unaccepted claims. They quantify the number of claims filed in a year, but they do not reveal the devastating experiences workers endure as a result of their workplace injuries.

CUTS TO THE WORKERS' COMPENSATION SYSTEM IN 2002

In 2002, the Gordon Campbell Liberal government made significant cuts to every aspect of the workers' compensation system, including prevention, compensation and vocational rehabilitation. Those cuts fundamentally eroded the core principles of the 1917 historic compromise, in which workers gave up the right to sue their employer in exchange for receiving compensation benefits when injured on the job.

The major restructuring of the workers' compensation system in 2002 was driven by the employer community, which claimed the system was economically unsustainable, and called on the provincial government to secure major cost savings. Reducing compensation benefit levels to 90 per cent of the worker's net income, eliminating lifetime pensions, and severely reducing vocational rehabilitation assistance, meant injured workers were now literally paying the price for their workplace injuries.

Seventeen years later, the WCB is funded at 155 per cent and has a surplus of $2.9 billion.

The 2002 cuts to the compensation system also included a reduction in health and safety protections for workers on the job. Cuts to regulations and prevention services, carried out in the name of reducing red tape, have meant fewer prescriptive regulations, office closures, fewer workplace inspections, and less enforcement. The result? More workplace injuries, less compensation, and fewer services for injured workers.

Those cuts also shifted the organization's culture, and moved WCB closer to the corporate world. New WorkSafeBC branding generated a corporate, insurance company appearance, which suggests a shift in emphasis away from the primary concern of providing workers' assistance to

WCB's financial bottom line. That shift also put the onus on the worker "to work safe" rather than putting the onus on the employer to provide safe work, perpetuating a "blame the worker" attitude.

A GENDER-BASED ANALYSIS

We fully support the government's application of a gender-based analysis to the workers' compensation system, and to the deliberations of the system's review. Workers' compensation legislation, policies and practices – in both compensation and prevention – must apply an intentional gender lens at the time of development, which is currently not the case in B.C.

Furthermore, enforcement of regulations and adjudication of claims do not apply an intentional gender lens either. Consequently, many women workers' injuries are misunderstood, misdiagnosed, and claims are denied.

As stated earlier, 85 per cent of the HEU's membership are women workers. MSIs and violence-related injuries are the two highest injuries among health care workers. In both cases, the injuries are largely invisible, and often considered "part of the job".

Anecdotal evidence tells us that many injuries go unreported because workers fear their claim won't be accepted, and they will pay the price financially if off work. Consequently, many work through their pain or exhaust their sick time, vacation time or family savings in order to recover. Special attention and examination of these types of injuries through a gender-based analysis is welcomed and long overdue.

CHANGE THAT MAKES A DIFFERENCE

Creating a workers' compensation system with a worker-centered service delivery model requires an understanding of the problems that arise out of injured workers' actual claims and experiences, as well solutions that will address those problems.

We are very appreciative that the workers' compensation review held public hearings all across B.C. These hearings provided workers a critical opportunity to talk directly about their experiences with the system, and make suggestions about how the system can be improved. According to our members who participated in the public hearings, the experience was validating, respectful, and they felt heard.

Achieving a worker-centered approach requires major legislative changes, as well as changes to policy and practice. Workers cannot continue to be held financially responsible for their injuries. The 2002 cuts to reduce compensation benefits to 90 per cent of net income means injured workers pay a 10 per cent financial penalty for being injured on the job.

The cut to compensation benefit levels further impacts other benefit amounts, such as loss of earnings and permanent functional impairment awards, because they are calculated as a percentage of the compensation benefit. This leaves workers with an overall 13 per cent cut to

benefits. It is critical that injured workers be fully compensated, which can only be achieved through legislative change.

In addition, workers cannot continue to be treated with disrespect and disbelief. Shifting the organizational culture to one of respect and dignity must begin with the Board of Directors and the senior executive team in their day-to-day actions, and through the lens they apply to their decision-making. It must also be communicated to all staff throughout the organization.

The HEU endorses returning to the fundamental principles for a fair and comprehensive workers' compensation system as set out in *Insult to Injury*, and fully supports the recommendations outlined in the paper, which detail the requirements for the return to a full compensation system. The HEU also fully supports the B.C. Federation of Labour's paper *Restoring the Balance: A Worker-centred Approach (2017).*

RECOMMENDATIONS AND CASE STUDIES

This submission outlines many of the problems HEU members currently face with the workers' compensation system, and provides recommendations regarding the changes required to create a worker-centered system.

Our recommendations are illustrated primarily through case studies. The stories from our members are plagued with chronic under-entitlement, mental distress, and loss of quality of life, arising directly out of their involvement in the compensation claim cycle.

Recommendation 1: *Amend the Workers' Compensation Act (WCA) to create a balanced Board of Directors.*

The WCA must be amended to create a balanced Board of Directors, where workers and employers have equal representation on the board. Currently, there is one worker representative and one employer representative. However, there are other positions on the board such as the OH&S specialist, the two public interest positions, and the health care position, which have been filled by individuals from the employer community for the past 15 years.

Implementing a worker-centered system requires a far more balanced perspective. It's time to return to equal representation on the board. It is in keeping with the legislation governing the composition of joint health and safety committees, and it is also in keeping with the majority of jurisdictions across Canada.

Recommendation 2: *Increase benefit levels to 100 per cent of net income.*

Benefit levels must be increased to 100 per cent of net income. As stated earlier, this has a cascading effect on many other benefit amounts that injured workers receive. This legislative change would begin to address a significant problem workers currently face and would no longer financially penalize workers for being injured on the job.

Recommendation 3: *Amend the application for compensation process.*

Recommendation 4: *Require the Board of Directors to create a system that documents conversations about claim-related issues.*

Case Study: *The current case management system is flawed.*

- A care aide was injured while transferring a resident when a Broda chair jammed and abruptly gave out, causing her to tear ligaments in her wrist and feel pain in her upper arm and shoulder.
- She immediately contacted the call centre, which coincided with the shift change process, and provided a brief account of the mechanism of injury.
- Her claim was only accepted for a right wrist injury.
- A month later, she called her case manager, where she found herself in a verbal disagreement about which conditions should be accepted.
- This call was never documented on the worker's claim file.
- One year later, she received a decision letter denying a right shoulder injury as a compensable condition on her claim file. The reasons cited for the denial were substantial discrepancies between her initial reporting of the mechanism of injury and the alleged delay in notifying the Board of her right shoulder symptoms.
- The Board contended that the worker only reported a shoulder injury four months after her initial injury, and denied that she ever had a conversation with the case manager.
- The Review Division (RD) confirmed the decision, which was largely based on alleged credibility concerns.
- The matter is pending a decision after an oral hearing at WCAT.

Specifically, we recommend that the Teleclaim process be significantly changed. The current Teleclaim process operates under the expectation that injured workers will be able to verbally provide a complete and comprehensive account of the mechanism of injury through one telephone call. This has had disastrous effects on claims from a credibility standpoint.

We recommend that WCB amend the Teleclaim process to acquire the worker's personal information only on the phone, including details about their occupation. The Board should then request that workers send in a signed letter, which will serve as the complete and full account of the mechanism of injury.

Further, the Teleclaim agent should advise the injured worker about the importance of this statement, and how it will guide the claims process. This would effectively eliminate many issues related to initial incomplete descriptions of the mechanism of injury, and allow Board Medical Advisers (MAs) to render their opinions using the correct description of the workplace incident.

We recommend that a new email system, or worker portal, be established to allow for a retrievable digital timeline for all correspondence between case managers and injured workers.

The current system allows telephone conversations and voice mail messages to case managers remain undocumented. This creates a huge problem for injured workers for two reasons. First, discussions about ongoing levels of impairment, unaccepted conditions, and requests for reconsideration can be omitted. This has an obvious detrimental impact on claims for injured workers. They are often told there is a gap in continuity of symptoms and symptom reporting, which leads to credibility concerns throughout the duration of a claim cycle.

In other situations, when a worker does not appeal in time and needs an extension of time (EOT), the undocumented phone conversations could serve as evidence to suggest they communicated their intention to appeal. Without that evidence, many EOTs have been denied.

> ***Recommendation 5:*** *Compel the Board to investigate all reasonably diagnosed conditions linked to the workplace incident or employment activities.*
>
> ***Recommendation 6:*** *Expand the Review Division jurisdiction to be broad and remedial.*
>
> ***Recommendation 7:*** *Amend the Review Division process to allow workers to choose their method of appeal similar to WCAT.*

Case Study: *The sprain/strain phenomenon.*

- The worker, a housekeeper, had her claim accepted for an elbow sprain/strain.
- The claim was only accepted for a sprain/strain, but the worker had new evidence suggesting it was likely a plexus traction injury (PTI).
- The Board received medical evidence from her attending physician (AP) suggesting that she actually has a PTI.
- The worker asked both the Board and later, the RD, about acceptance of that condition.
- The Board did not action her adjudication request, and instead, issued a decision advising that her compensable sprain/strain had resolved.
- The RD ignored her request, and did not bring up the issue during the Review either as a "preliminary matter", regarding jurisdiction, or a comment in the "reasoning" that the matter had not been adjudicated, and the worker was free to ask the Board for acceptance.
- The union formally requested acceptance of a PTI, several months after the worker's request was made.

Specifically, we ask that the Board adjudicate new or differential diagnoses once medical evidence – relating these conditions to workplace activities – is received.

This will allow for comprehensive claim management rather than relying on the current sprain/strain phenomenon, in which the Board obtains further medical opinions using only strain/sprain as the first and only accepted diagnoses. Moreover, this change would put the onus of investigation back on the Board.

Currently, injured workers are expected to have an advanced understanding of the system, or risk appealing the wrong decisions in relation to their desired outcome.

The Board and the RD use form language such as "the worker is free to ask the Board to adjudicate further diagnosed conditions if they choose to." As we know, this essentially means that the worker is to put in a request in writing for new adjudication. However, often times, they will instead call case managers, who will not action these requests. The Board should also be compelled to provide an accurate timeline for a decision on a new adjudication, whether it is initiated by them or the injured worker.

Currently, there is no timeframe for such requests.

In addition, expanding the RD would compel the RD to consider differential diagnoses so that claim resolution and medical plateau reviews could proceed using the correct diagnosis rather than only using the accepted compensable condition. This would prevent workers from going through an endless appeal cycle, or having to request new adjudications.

Finally, amending the RD process to allow workers to choose their method of appeal similar to WCAT, would allow injured workers to address credibility concerns during the first level of appeal. Currently, the RD does not regularly conduct oral hearings, and largely relies on the Board's initial findings of fact to make their decisions.

> ***Recommendation 8:*** *Board MAs should be held accountable for their medical opinions.*

Case Study: *Claim acceptance.*

- A worker-to-worker car accident occurred on the way to work.
- Only minor bumps/bruises were detected at the scene.
- Four weeks after the accident, the worker experienced a sudden onset of Benign Paroxysmal Positional Vertigo (BPPV), a condition he had never had before.
- The claim was denied due to an MA opinion that was rendered using an erroneous diagnosis of "non-specific vertigo" as the working diagnosis. The reasons cited to deny the claim were the time that had elapsed since the accident (four weeks) and the onset of BPPV as not being "biologically plausible" from a causation perspective.
- The worker's physiotherapist indicated that one of the causes of BPPV is trauma to the head and neck, and that it is possible to have onset of symptoms a few days following a post-traumatic episode.
- We further researched the matter and enclosed medical literature, which noted that "post traumatic BPPV can occur immediately or may be delayed by weeks or months." In addition, it explicitly noted that "the head trauma does not necessarily need to be severe to elicit BPPV."
- The RD obtained an RDMA opinion which confirmed that this was indeed the case.
- The worker's claim was accepted.

Currently, we are not aware of any systems in place to measure accuracy and consistency of Board MA opinions. We recommend that a new system be put in place to hold MAs accountable for their opinions, and not simply provide conclusory medical opinions using an erroneous diagnosis, occupational disability guidelines, or an incorrect timeline.

The Board should provide them with continued case consultations/education to ensure consistency of medical opinions in cases involving analogous fact patterns. Presently, it is unlikely that the previous case study led to any real change in how the WCB adjudicates claims for trauma-induced vertigo.

> ***Recommendation 9:*** *Implement an expedited review process or independent medical review panel for decisions that have an immediate financial impact on injured workers.*

Case Study: *Selective/light duties.*

- A housekeeper was injured when a heavy item fell on her wrist.
- The claim was accepted for wrist contusion.
- The worker had a prior claim history of pre-existing de Quervain's tenosynovitis, and advised the Board that the symptoms were virtually identical to the injury.
- The employer offered modified duties.
- WCB, through a nurse's opinion, concluded that "the modified duties were within the temporary limitations for a wrist contusion and could have been performed using the worker's non-injured dominant hand."
- A premature/erroneous diagnosis was used as the factual basis to render a decision that found the worker was unreasonably refusing modified/light duties.
- Her wage-loss benefits were terminated, and she was found to be eligible only for health care benefits.
- Five days after the Board decision was rendered, a VSC doctor opined that the worker clearly aggravated her pre-existing de Quervain's tenosynovitis. This finding was based on a "markedly positive Finkelstein's test on the left", which included a "markedly swollen" left wrist.
- Surgery was scheduled to take place within six weeks of the report, and hand therapy as soon after surgery as possible was recommended.
- A written reconsideration request was sent to the WCB.
- The matter was not reconsidered.
- The worker was successful at RD.
- It took six months from the date of decision before a correct decision was made.
- Impact on the worker: The worker fell into an emotional spiral as she had to rely on her family for financial support pending the RD decision.

This case provides a snapshot of WCB's current application of the selective/light policy, in which they rely on medical opinions from practitioners who do not physically examine the worker. Moreover, premature decisions were made on this matter without completing appropriate medical investigations to obtain a full and definitive medical diagnosis.

Furthermore, no weight was given to the recommendations provided by the worker's AP or follow-up reports, which clearly indicated the wrong diagnosis was being used. Lastly, the Board did not respond to a reconsideration request, leaving the worker to bear the financial burden of waiting several months without wage-loss benefits.

An expedited review process, or medical review panel, would greatly benefit selective/light cases. It would prevent injured workers from attempting to return to work while injured or having to access EI or Income Assistance benefits which are substantially less than wage-loss benefits.

Case Study: *Selective/light duties.*

- A worker sustained a left foot/hindfoot injury, which was suspected to be an Achilles tendon rupture.
- The employer provided a list of modified duties.
- The MA opined, "the modified duties would not place an undue risk on the worker's Achilles tendon rupture. He could ambulate with crutches for short distances when needed."
- The worker attempted modified duties and found that the duties were substantially different than those presented to the WCB. He was required to walk short distances on his crutches, and then stand for prolonged periods of time at a computer station (no sit/stand or modifications available).
- When he had to print documents, he had to walk further to retrieve them.
- The worker's AP provided a letter to WCB stating he can only safely perform sedentary duties as he is at risk of further injury.
- The WCB did not respond to the AP's letter, and advised the worker to return to work.
- The worker attempts light duties for four weeks and has an incident, where he slips on his crutches and lands on his injured leg. He ceases participation in light duties.
- The WCB deemed it an unreasonable refusal and calculated temporary wage-loss benefits by deducting light duty benefit for hours he could have worked had he not refused.
- The MRI confirmed Achilles rupture.
- The orthopedic surgeon later stressed that the worker must remain completely non-weight bearing.
- The worker had to bear the burden of undue financial pressure by discontinuing light duties that were not suitable for him.
- The worker appealed to RD and the worker was successful. It took six months from the date of denial until the worker received this decision.

Recommendation 10: *Reconsiderations need to be mandatory if new medical evidence is received within 75 days of the original decision. These decisions should be made by designated Reconsideration Officers.*

Case Study: *Modified duties.*

- The worker injured his back, and reported hearing a pop as well as feeling severe pain.
- The claim was accepted for low back sprain/strain.
- The MA speculated that the most likely diagnosis is a low back sprain, and stated the worker should be referred to a "VSC for diagnostic clarification and treatment recommendations."
- The employer offered modified duties, and the Board agrees he can go to work despite it being clear that the worker did not have a definitive diagnosis to explain his significant pain symptoms.
- The worker attempted to perform the modified duties. He realized the modified duties were not the same as those provided to the Board. Specifically, he was required to pull excessively heavy bins.
- The worker informed the Board, who never investigated nor spoke to the employer about these concerns.
- The worker decided not to risk further injury, and discontinues the modified duties.
- His wage-loss benefits were terminated.
- The worker ended up losing out on several months of wage-loss benefits. He only received a total of three weeks of wage-loss benefits prior to being cut off for refusing 'reasonable' selective/light duties.
- A consult report from a neurosurgeon, three months after his benefits were cut off, revealed the worker had a left foraminal disc herniation at the L3-4 level and a foraminal disc osteophyte complex on the left at the L5-S1 level, and a slight bulge laterally at the L3-4 level. At the L5-S1 level, there was also a tiny osteophyte with associated disc bulge.
- Several months later, his review was successful.

The speculative diagnosis of a low back sprain/strain was completely erroneous and led to months of frustration and financial distress for the worker, in which he had to apply for medical EI and survive on a fraction of his wages with no health care benefits to treat his condition. At the time he appealed this decision, he had just started taking anti-depressant medication, which he attributed to the financial distress and frustration with dealing with WCB.

Currently, the WCB treats these requests as optional, and usually does not reconsider them at all, ignoring the request and allowing 75 days to elapse. We recommend the WCB have designated reconsideration officers to make these decisions rather than rely on the original case manager's to reconsider their own decisions.

Case Study: *Plateau decisions.*

- The worker was injured while lifting a resident from the ground to a wheelchair in November.
- Her claim was accepted for a right elbow sprain/strain.
- In March the following year, she attended an OR1 program and was discharged as fit to return to work without limitations.
- June 2: an MRI revealed a right distal bicep tear.
- July 25: WCB issued a decision terminating wage-loss benefits, accepted two permanent conditions, and deemed the worker fit to return to her pre-injury job. WCB speculated that "a pending orthopedic consult is not expected to result in a surgical recommendation."
- August 19: the worker was examined by an orthopedic surgeon, who has advised complete immobilization in an elbow brace as conservative treatment before likely proceeding with surgery.
- The doctor advised that surgery was a likely option, as they have decided to test out these conservative measures, before proceeding to a surgical procedure involving detachment of the distal biceps and reattachment to the radial tuberosity.
- HEU requested a reconsideration of the Board's July 25th decision letter, considering the August 29th consult report directly contradicted that decision.
- The Board did not reconsider its decision.
- The worker underwent surgery in September of that year.
- The worker waited several months through the Review process before it was determined she was not at medical plateau at the time the July 25th decision was rendered.

A mandatory reconsideration process, expedited Review, or Medical Review Panel would have been of great benefit to this worker's case. Instead, she had to wait several months without any income to finally be successful on appeal.

Case Study: *Plateau decisions.*

- A worker fractured his ankle as a result of a workplace accident.
- Following several surgeries, WCB determined that his condition reached medical plateau.
- They accepted chronic left ankle pain on the claim file, and provided him with a 2.5 per cent award.
- The worker was upset and was told to appeal the decision.
- Requesting a review of this decision would have been a waste of time since there is no provision for a chronic pain award greater than 2.5 per cent.
- The union called the case manager, advising they had not referred the file for a Disability Awards Medical Advisor (DAMA) assessment. The case manager confirmed this step was missed, and made the correct referral. Six months after the DAMA assessment, the worker received a new decision from Disability Awards; his PFI was increased from 2.5 per cent to 16 per cent. The Board accepted the range of motion loss in the left ankle, the left hindfoot, and sensory/nerve damage.

Common problems in plateau decisions:

- They are premature. There are still medical investigations that would provide a much clearer picture regarding a worker's diagnosis, the severity of the injury, treatment plan, and ability to participate in VR.
- These decisions are largely based on the "discharge status" of Occupational Rehabilitation 1 (OR1) and Occupational Rehabilitation 2 (OR2) programs.
- In each progress report, the OR program providers always indicate the worker is "anticipated to be discharged as being fit to return to work without limitations."
- Many times, these OR report discharge statuses are not consistent with the actual details of the report, which will document that the worker continues to report disabling pain symptoms and limitations that preclude them from demonstrating the functional abilities to return to pre-injury job duties.
- Sometimes, when workers refuse to participate in functional weight-lifting activities, the OR program therapists will document speculative opinions that the worker would have been able to complete the activity had they participated, so the discharge status is still fit to return to work despite no demonstrated objective proof.

The Board case managers place significant weight on this discharge status without looking at the totality of the medical evidence on file. As such, the OR reports serve as the evidentiary basis to terminate a worker's wage-loss benefits.

Recommendation 11: *Eliminate Psychological Disability Awards Committee (PDAC) as an expert evaluator of psychological PFI cases.*

Case Study: *Problems with PDAC.*

- The worker, a switchboard operator, contacted the union wanting to appeal an April 29, 2019 Board decision that set her permanent functional impairment (PFI) for her compensable post-traumatic stress disorder (PTSD) at 15 per cent, effective April 6, 1995. The worker's PTSD resulted from a sexual assault at work.
- The worker returned to work in 1995, and temporarily wage-loss benefits were terminated. However, it appears the Board never made any further decisions regarding her claim. This was not realized until April 2018 when the worker contacted the Board requesting a reopening of her claim. After her claim was reopened, the case manager made a referral of the worker's claim to the Disability Awards Department, and she was given a disability award retroactive to 1995.
- The failure to make this decision in a timely manner resulted in $58,000+ retroactive payment to this worker – money that she could have used over the years. Upon a review of the medical on this file, the worker struggled since 1995 with her mental health and with concerns that WCB never adequately helped her. She was not aware of her entitlement to a disability award until 2018.
- The case is now pending an appeal arising out of the PDAC's decision to only provide the worker with a 15 per cent PFI, despite the horrific details surrounding her two

workplace incidents, and the significant way in which her life was altered as a result of the 1995 incident.

Case Study: *Problems with PDAC.*

- On September 16, 2016, the Board rendered a decision letter rating a worker's psychological PFI at zero per cent.
- By way of a March 21, 2017 RD decision, the matter was referred back to the Board for further investigation with the possibility of a new psychological assessment. The worker underwent a new psychological assessment in May 2017. However, the findings were minimal due to the worker's inability to participate as a result of her psychological symptoms.
- In a September 21, 2017 decision letter, the worker's psychological PFI was found to remain at zero per cent.
- PDAC solely relied upon the latest psychological assessment to come up with the zero per cent rating.
- In the months leading to the deemed plateau date, the available medical documentation indicates the worker needed to see a psychologist on a regular basis and take three kinds of psychiatric medication. She was assessed as emotionally fragile and subject to relapse. Her psychologist considered her somewhat emotionally fragile, and restricted from physically demanding work. She was still experiencing anxiety and depressed mood, and was a medium suicide risk. In this context, the PDAC's zero per cent was very difficult to comprehend.
- We used the reports on file submitted by the worker's Board psychologist and her own psychiatrist to argue that the worker's true psychological PFI rating should have been 35 per cent.
- The worker's review was successful, and her psychological PFI was increased from zero per cent to 35 per cent. It took almost 18 months from the original Board decision for her to receive this award.

These case studies clearly illustrate the need to eliminate PDAC in the process of providing a rating for psychological PFI.

We recommend that the policy be amended to utilize a multidisciplinary approach using the psychological assessments, consult reports, and other medical evidence on file to quantify a psychological PFI rating. As is the case with other disability awards, the responsibility should fall on a disability awards officer.

In recent years, we have been advised that 86 per cent of psychological PFI award appeals were being overturned. This is an alarming number of cases, and raises questions regarding the credibility of PDAC. Furthermore, it begs the question of how many workers are accepting these low ratings without appealing the corresponding decisions, given their level of impairment associated with their psychological condition.

Recommendation 12: *Clearly define the labour relations exclusion as outlined in Section 5.1(c) of the Act.*

Recommendation 13: *Amend the current investigation process for bullying and harassment claims to allow for discrete investigations with the ability for witnesses to remain anonymous.*

Case Study: *Bullying and harassment.*

- The worker's claim was denied using section 5.1(c), despite evidence that the worker's employer used intimidation, coercion and threats of discipline to coerce her to resign from her employment.
- WCAT initially denied acceptance of the claim citing decisions made about the worker's employment.
- The worker had to go through a Judicial Review (JR) until this decision was deemed to be patently unreasonable.

The Board uses broad discretion in applying this subsection of the Act. A clearly defined addendum to this policy is needed to prevent cases as outlined above. The fact that the worker had to endure years fighting her claim and go so far as a JR is unacceptable.

Current field investigations for section 5.1 bullying and harassment cases clearly identify co-workers and managers by their first names and last initials. This leads to vague witness statements and ultimately, the Board reaches a conclusion that there is not enough evidence to accept a worker's claim.

The Board needs to modify its investigation process for claims involving worker-supervisor, or worker-worker bullying and harassment to account for the sensitive nature of these claims, and to allow for an independent investigation in which co-workers do not have to fear they will be identified and retaliated against.

Recommendation 14: *The Board needs to apply Section 21(1) in accordance with the Act.*

Case Study: *Health care benefits.*

- The worker was denied ongoing chiropractic treatment.
- The decision letter contained the following form language regularly used by the Board for health care benefit cases post-medical plateau:
- "At the time that a worker is injured, the Board provides health care benefits to support recovery from the acute symptoms related to the compensable conditions. After the condition reaches maximum medical recovery, it is the worker's duty to maintain that level of recovery by seeking their own treatment through extended health or MSP benefits. Therefore, your request is denied."

- At the time of the decision letter, the worker's AP noted the worker was taking an alarmingly high dose of six pills of Emtec-30 per day to manage his chronic low back pain. Since commencing his treatment, the worker made extraordinary improvements; these improvements were so drastic that the worker has been able to completely discontinue use of Emtec-30.
- The AP further cautioned that the worker would jeopardize his health, if he had to go back on narcotic pain killer medication.
- The review was successful, and the worker was entitled to ongoing reasonably necessary chiropractic treatment to cure, alleviate or relieve the effects of the compensable injury.

Injured workers requesting further health care benefits in the form of physiotherapy, chiropractor, acupuncture etc. after medical plateau regularly receive a form letter from the Board indicating the worker is now responsible for their own health care.

This is an erroneous interpretation of Section 21(1) of the Act. Although we have been largely successful in reviewing these decisions, these types of decisions should not be made. Again, an independent ombudsperson could help ensure that the Board is correctly applying law and policy.

> ***Recommendation 15:*** *Make vocational rehabilitation (VR) services mandatory.*
>
> ***Recommendation 16:*** *VR must be made mandatory with the payment of retroactive benefits for successful appellate returns, in which the VR plan is found to be unsuitable.*
>
> ***Recommendation 17:*** *All decisions made on entitlement must be communicated to the injured worker.*

Case Study: *Vocational rehabilitation (VR).*

- A worker sought an EOT for VR suitability decision.
- EOT granted due to language barriers, in which he was unable to comprehend written English especially given the context that the Board did not provide him with a verbal decision with an interpreter.
- He was in receipt of a PFI award for an aggravation of pre-existing PCL and MCL injuries as well as chronic pain in the knee.
- The worker reviewed the decision contesting the finding that a delivery driver was a suitable occupation for him.
- The AP cautioned that the worker's use of pain killer medication, along with the risk of exacerbation of pain symptoms due to frequent accelerating and breaking of a vehicle, make this position unsuitable for the worker.
- The AP also emphasized: "the worker has poor comprehension with the written, audio and oral English language skills. Therefore, the above would definitely pose a major

concern that he would not be able to complete the duties to the expected level for a Delivery and Courier Service Driver. When he visits my office, he solely converses in Farsi his native language and when it comes to completing forms he always needs my assistance."

- The VR plan was found to be unsuitable. Given the circumstances surrounding the EOT, this process took 11 months. RD issued a decision on the merits of the case three months after the EOT was granted.
- *Implementation of decision:* The worker was granted VR planning benefits only as of the date of the RD decision letter; effectively disentitling him out of 11 months of retroactive wage-loss benefits despite the plan being unsuitable.

VR should no longer be considered a discretionary benefit. Furthermore, if a worker is unable to participate in VR due to functional limitations/restrictions, the VRC should either modify the plan to accommodate the worker's current levels of limitations, or send the file back for further investigation to determine whether a significant change warranted a reopening. Simply discontinuing a worker's VR benefits is not appropriate in an investigative system.

If a worker is successful on appeal in arguing that the current VR plan is unsuitable for them, they should receive retroactive VR benefits from the time the decision under appeal was rendered. Currently, the Board reinstates benefits only from the time the RD decision was made. Again, the worker pays the price for the Board's inaccurate assessment and there's no penalty for the Board. All too often, injured workers fall into a cycle of poverty due to having their income replacement VR benefits terminated. Many workers end up on EI for the short-term and then Income Assistance/PWD.

All decisions regarding entitlement benefits must be communicated to injured workers verbally in their first language. In special circumstances, the Board should also consider sending decision letters in the worker's first language.

The Board has their own language line with interpreters to make calls to injured workers. Currently, the Board sends a decision letter, written in English, to a worker and places the burden of translation back on the worker. The current process creates a huge burden on workers and their representatives to effectively attempt to acquire their rights to appeal through the extension of time process.

Recommendation 18: *The VR process needs to place a greater emphasis on employers' duty to accommodate.*

Case Study: *Vocational rehabilitation (VR) and duty to accommodate (DTA).*

- A 57-year-old food services work injured her right thumb in March 2017, and the claim was referred to VR in January 2018. This worker has worked in different roles (cooks helper and food services worker/nourishment aide) for Fraser Health Authority and affiliates for 30 years – since January 1989.
- The VRC "spent the past year trying to identify a suitable plan to facilitate the worker in returning to work with her pre-injury employer." On December 12, 2018, the employer

confirmed they were not able to accommodate worker in a suitable phase two employment.

- The worker wanted to remain with her pre-injury employer as she was so close to reaching her pension (by age and years of service), so she identified a number of jobs that she knows she could do with her pre-injury employer and discussed this with VRC. However, the VRC simply went along with what the employer said, and did not investigate this further.
- The accepted limitations were: gripping with activation of her right thumb; lifting more than 10 pounds and only on an occasional basis; working in cold environments; and limited tolerance for pinch gripping.
- Initially, the Board sponsored the worker to attend training with the Academy of Learning, in hopes of being able to return to the pre-injury employer in other roles. There was no actual VR plan set up for this program, and just before the worker had successfully completed the admin program, the VRC issued a VR plan finding that the occupation of security guard would be suitable for, and reasonably available to, the worker.
- They expected the worker to drop out of the admin program just weeks before it was completed, and to start the VR plan for security guard.
- While there were some concerns by the Academy of Learning initially regarding the worker's ability to achieve a suitable score for typing speed, the worker surpassed all expectations and was close to completing the program and potentially remaining employed with her pre-injury employer.

The current VR system allows employers to circumvent the DTA. Without showing reasonable due diligence, or that accommodation would cause undue hardship, the employer can claim they do not have a job to accommodate the worker's limitations and restrictions.

This leaves too many injured workers with the prospect of embarking on a new career path in the latter part of their working lives. This process also causes catastrophic financial damage to injured workers since they lose their pensionable service, and effectively lose out on potential retirement pensions.

And lastly, this process leaves many injured workers feeling humiliated and hopeless, as they leave behind their careers to enter a new field at entry-level jobs.

Recommendation 19: *Diagnosed psychological conditions arising out of all issues, undue delay must be compensable.*

Case Study: *Undue delay.*

- The worker's file was transferred to the VR department in mid-2017 for a skills assessment.
- On November 20, 2017, the VRC (at the time) had an interview with the worker for purposes of creating a VR plan.

- On December 18, 2017, the VRC spoke to the pre-injury employer, and determined that phase II would be ruled out and a deemed VR plan would be developed.
- This was not discussed with the worker, and there was no further communication regarding VR with the worker from the time of the VR interview in November 2017 until March 2018, when the worker was informed by letter that a different VRC was being assigned.
- No further communication was made with the worker regarding VR following that letter until October 2018, when the worker was copied on a decision sent to her pre-injury employer confirming there was no phase II position available (based on the determination made almost a year prior on December 18, 2017), and that the worker was entitled to wage-loss equivalency and possible retraining.
- No one contacted the worker to explain what this meant, and no wage-loss equivalency or VR services were provided to her.
- On November 1, 2018, the worker contacted the Board to discuss a number of issues, including a decision the Board neglected to make regarding the worker's entitlement to temporary wage-loss benefits following an April 2018 RD decision, and the status of the VR referral for her file.
- The case manager told the worker that her VRC was to complete a deemed VR plan, and a further decision would be sent to her indicating whether she met the requirements for a loss of earnings assessment. This was not done.
- In April 2019, our office followed up with the worker's case manager to determine the status of the deemed VR plan for the worker. On May 2, 2019, we received a voice mail from the worker's then VRC saying that ideally the plan would be completed by May 13, 2019, or barring that, by May 27, 2019.
- No decision was issued by May 27, 2019, and no communication was received from the VRC by either our office or the worker regarding any further delays.
- On June 24, 2019, our office left a voice mail for the worker's then VRC asking for an update on the status of the VR plan, as it had been almost a month since the anticipated timeframe in which the decision would be issued, and we had not heard anything or received a decision.
- On June 26, 2019, our office received a call from the worker's VRC indicating that there had been some "pretty significant staffing changes in May and June" and some "issues with upper management". The VRC indicated that the worker's file had been assigned to a new VRC, but that neither of them could provide an anticipated timeframe in which the VR plan would be issued, and that she could not provide the contact info for the new VRC. Neither of these calls are documented on the worker's file.

If a worker develops a psychological disorder due to undue delays and frustration with the Board in scenarios such as the previous case study, the Board should not be able to deem these to be non-compensable factors in the development of psychological conditions.

OTHER RECOMMENDATIONS

Recommendation 20: *Interest must be paid on payment of retroactive benefits in all successful reviews and appeals.*

Workers consistently receive retroactive payments – and as of 2002, they do not receive interest on the payments, but should be provided with interest. Currently, there's no deterrent to the Board making premature decisions. The WCB in British Columbia is seemingly one of the only jurisdictions that does not pay interest on retroactive benefits for successful appeals.

> ***Recommendation 21:*** *Replace the Fair Practices Office with an independent ombudsperson who is not internal to the Board.*

We further recommend that this new office create a quality control position within the ombudsperson's office to ensure the correct claim management processes are followed: i.e. formal decisions on claim resolution or permanent conditions are actually made. Alternatively, once a worker's claim is deemed to be at medical plateau, a referral to disability awards must actually be completed.

> ***Recommendation 22:*** *Compel the Board to include field investigation surveillance in requests for disclosure.*

Injured workers have the right to know when they have been under surveillance.

> ***Recommendation 23:*** *Allow physicians to directly receive pre-authorization to write medical-legal opinions for the purposes of worker reviews and appeals.*

This will help alleviate the financial burden imposed on workers as they currently have to solely bear the burden of costly medical opinions for appellate purposes.

> ***Recommendation 24:*** *Amend policy #40.00 to include circumstances in which a worker, despite reasonable efforts, is unable to obtain employment in the target VR occupation.*

Instead of discontinuing job search benefits, the Board should provide the worker with a new VR plan, since the original one has for all intents and purposes, failed.

> ***Recommended 25:*** *A new system, to make findings of facts related to acceptance of limitations and restrictions, needs to be implemented.*

These findings should be made once conditions are accepted as permanent. Once a condition is accepted as permanent (including chronic pain), the Board should investigate what associated limitations and restrictions are present. The Board should also provide the worker with 30 days to submit their own medical evidence from their doctor as to what limitations and restrictions are associated with the diagnosed conditions.

Recommendation 26: *Amend the current Activity-related Soft Tissue Disorder (ASTD) policy to include the merits and justice of each individual case. Accept computer-related soft tissue disorders.*

The Board's current ASTD policies and practice directives contain outdated medical science that largely requires the presence of force, awkward postures, repetition, and unaccustomed duties. This "one size fits all" approach precludes individual analysis based on the merits and justice of each individual case.

The current application of this policy effectively bars all computer-related ASTDs, since they do not have the requisite force that the Board requires to accept these claims. Yet, year after year, our members develop ASTDs due to prolonged computer usage.

Recommendation 27: *Disability awards should apply the "make whole principle", and therefore be payable for the duration of the injured worker's life.*

Since a disability award recognizes the lifelong effect of a permanent workplace injury, it does not make sense to have the disability awards terminate at age 65. To truly put an injured worker in the position they would have been in – had they not been injured at work – anything but a lifelong pension is an inequitable result.

Recommendation 28: *Apply section 99(3) of the Act and policy #97.00.*

WCB rarely applies this provision of the Act and policy, and seemingly operates under the presumption that the WCB MA opinions carry more weight than those of attending physicians and other treatment providers. In our experience, the evidence is often equally weighted, but the WCB is not applying the section of the Act correctly. Indeed, we were unable to find one case study, in which the evidence was found to be evenly weighted.

Recommendation 29: *Elimination of gender-based pronouns in all Board correspondence.*

We recommend that the Board update its letters to remove gender pronouns and address correspondence to injured worker without containing a pronoun.

Recommendation 30: *Loss of earnings where greater than PFI awards should replace PFI awards.*

All loss of earnings, if greater than PFI award, should replace the PFI award. This practice would be consistent with the make whole principle, rather than allowing the Board to continue its current practice of only finding a significant loss of earnings if there is a 25 per cent loss of earnings.

Recommendation 31: *Equitable awards for chronic pain.*

Amend the law and policy to provide an equitable award for chronic pain. The current provision of 2.5 per cent is unacceptable. We recommend that the policy be amended to consider chronic pain on a scale from low, moderate and severe; ranging from 0-30 per cent in 10 per cent intervals. Acceptance of chronic pain should also result in a mandatory investigation into associated limitations and restrictions related to the chronic pain condition.

CONCLUSION

The HEU is pleased to have participated in the workers' compensation review process. As is evident from the case studies presented, workers pay the price in so many different ways for being injured on the job.

Furthermore, the lack of communication, lack of respect, and long delays can cause further psychological injury for which the system is not held responsible. A worker-centered workers' compensation system, where workers receive full compensation and the respect they deserve, requires a major overhaul of the current WCB system.

We call on the government to move quickly on the recommendations of the review, and make the changes required to establish a truly worker-centered workers' compensation system.