

Quality of Physiotherapy Services for Injured Workers Compensated by Workers' Compensation in Quebec: A Focus Group Study of Physiotherapy Professionals

Qualité des services de physiothérapie chez
les travailleurs qui reçoivent une indemnisation
de la Commission de la santé et de la sécurité
du travail au Québec : groupe de discussion
réunissant des professionnels de la physiothérapie



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Abstract

Musculoskeletal disorders are among the leading causes of work-related physical disability in the province of Quebec in Canada. The authors conducted a focus group study with physiotherapists and physical rehabilitation therapists working with patients whose treatments are compensated by the Quebec Workers' Compensation Board with the goal of exploring quality of care and ethical issues. Three main themes were identified: (1) *systemic factors*, (2) *complexity in treatment decisions* and (3) *inequality of care*. Although physiotherapy professionals strive to give these patients the best possible care, patients might not always be provided with optimal or equal treatment. When compared with other patients, there appear to be differences with respect to access to care and types of services offered to injured workers, raising equity concerns. Factors that shape and constrain quality of physiotherapy services for injured workers need to be addressed to improve care for these patients.

Résumé

Les troubles musculosquelettiques figurent parmi les principales causes d'incapacités physiques attribuables au travail dans la province de Québec, au Canada. Les auteurs ont dirigé un groupe de discussion réunissant des physiothérapeutes et des thérapeutes en réadaptation physique dont les clients reçoivent une indemnisation de la Commission de la santé et de la sécurité du travail, et ce, afin d'étudier la qualité des services et de se pencher sur des questions d'ordre éthique. Les auteurs ont identifié trois principaux thèmes : (1) *les facteurs systémiques*, (2) *la complexité des décisions pour le traitement* et (3) *l'inégalité des soins*. Bien que les professionnels de la physiothérapie s'efforcent de donner aux patients les meilleurs soins possibles, ces derniers ne semblent pas toujours recevoir des traitements optimaux ou égaux. Comparés à d'autres patients, il semble y avoir des différences quant à l'accès aux soins et au type de services offerts, ce qui soulève des préoccupations quant à l'équité des services. Pour améliorer les soins qui leur sont offerts, il faudra se pencher davantage sur les facteurs qui influencent la qualité des services de physiothérapie pour les travailleurs victimes d'un accident de travail.



Introduction

In Quebec, a province of Canada, musculoskeletal disorders are among the leading causes of work-related physical disability and are very costly in terms of treatment, lost productivity and diminished quality of life (Lebeau and Duguay 2011). These disorders constitute almost 37% of occupational injuries compensated by the Quebec Workers' Compensation Board, the Commission de la santé et de la sécurité du travail (CSST) (IRSST 2013). The CSST is a cause-based medico-legal system (Lippel and Lötters 2013) aiming at compensating injured workers after an injury sustained at work. Like other workers' compensation boards in Canada, as well as their counterparts in most Anglo-Saxon countries, the CSST considers the eligibility of injured workers' claims based on the cause of the injury, meaning that the

injury must have happened at work and during work paid time to be eligible for compensation (Association des commissions des accidents du travail du Canada 2014). Laws regulate the functioning of the compensation process, and the CSST has the mandate of enforcing these laws with respect to compensation for medical care and for physical, social and vocational rehabilitation.

In the Quebec system, when a work injury is declared, the physician evaluates the patient, determines the diagnosis and confirms that the injury has been sustained and caused by work. If the physician's evaluation demonstrates that the injury was caused by their work, this information is sent to the CSST to support the injured workers' claim for compensation. Once the claim is accepted, the injured worker is entitled to receive different compensations such as replacement wages and medical benefits, as well as rehabilitation treatments such as physiotherapy. Indeed, as physiotherapists (PTs) are specialists in the musculoskeletal system, they are often implicated in the evaluation and treatment of persons with musculoskeletal injuries, including work-related back or neck pain and soft-tissue strains (Johnston et al. 2012). When physical work-related injuries are diagnosed by the physician, he or she often refers injured workers to physiotherapy clinics for treatment. The CSST then mandates the PTs involved in treating injured workers to improve their functional abilities and to prepare them for a safe return to work (RTW) (commission de la santé et de la sécurité du travail 2010). However, as the CSST system is a medico-legal system, even if the primary healthcare professional involved in the care of an injured worker is a physiotherapist, the treating physician is still recognized as the principal healthcare manager of the worker's case. The physician usually sets the parameters for the process of care and the RTW, and is the person responsible for transmitting this information to the CSST board. The physician is the only healthcare professional who makes decisions relating to supplementary imaging or investigations, change in RTW plans and ending treatment. Most of the time, the treating PTs will be responsible for informing physicians of the progress of the patient and options for RTW. Preferably, the RTW decisions would be made by the physician in conjunction with the treating physiotherapist, the CSST case manager, other involved healthcare professionals, the employer and the worker (Briand et al. 2008).

It is also important to note that even if Quebec has a public system of healthcare, most workers covered by the CSST and requiring physiotherapy treatment are seen in private, for-profit clinics, rather than in public physiotherapy departments located in hospitals or rehabilitation centres (Fédération des cliniques privée de physiothérapie du Québec 2010). In the private sector, the CSST reimburses the clinic owner for treatments provided to patients covered by workers' compensation on a fee-for-service basis. This high proportion of patients treated in private clinics rather than in public institutions might be attributable to the low accessibility of physiotherapy care in public settings throughout the province (i.e., the presence of long wait lists for accessing physiotherapy) (Camiré 2010; Commission de la santé et de la sécurité du travail 2010; Conseil du patronat du Québec 2010; Healy 2007).

In recent years, the CSST has implemented a strategic plan in order to increase accessibility, satisfaction and quality of care (QoC) for injured workers, while attempting to reduce rehabilitation costs. In its 2010–2014 strategic plan, the CSST defines ways of improving QoC by describing three essential aspects: better access to care services for all injured workers, more effective case management of workers presenting with serious injury or risk of chronicity, and simplification of the bureaucratic and administrative procedures associated with the CSST system (e.g., by improving technological support) (CSST 2010). In the United Kingdom, the Institute of Medicine has identified six central dimensions through which QoC is expressed: safety, effectiveness, patient-centredness, timeliness, efficiency and equity (The Health Foundation 2013). QoC is central to achieving the main goals of the healthcare system and specifically of physiotherapy: improving the health (and functioning) of patients, and enhancing patient satisfaction (Andersen 2008). However, there remains uncertainty regarding whether patients covered by the CSST receive high-quality physiotherapy services (i.e., safe care, appropriate care for their condition, timely access to care, integrated and patient-centred care, and equitable provision of care) and, if not, what barriers to high QoC exist (Laliberté and Hudon 2013; Laliberté and Hudon 2014).

Some organizational factors (related to the clinic's rules and/or the process and programs of care) have been recognized as having an impact on the QoC for patients covered by workers' compensation boards in Canada (MacEachen et al. 2010), and in also many different countries (Kilgour et al. 2014). For example, in Quebec, the fees used to compensate physiotherapy care are much lower than what PTs usually receive when offering care to privately insured patients (i.e., \$36 for patients covered by CSST compared to the average of \$59.90 in Quebec private physiotherapy clinics) (Fédération des cliniques privée de physiothérapie du Québec 2010). This gap in remuneration could be seen as a disincentive for PTs to treat patients covered by workers' compensation boards. Additionally, PTs providing care to patients covered by the CSST are part of a complex system including the patient and his family, the CSST case managers and advisors, the physician in charge of the patient, the employer, the patient's supervisor and colleagues, and other healthcare practitioners involved in the case. Some administrative constraints (e.g., paperwork, payment scheme) also have been shown to increase the organizational pressure on healthcare professionals and can impede the quality of treatments for patients (Kilgour et al. 2014). Research from Canadian and Australian researchers indicates that systemic features of some workers' compensation systems pose potential barriers to the provision of high QoC for compensated patients treated in physiotherapy (Kilgour et al. 2014; MacEachen et al. 2010).

In addition, ethical considerations have recently been raised in the Quebec media regarding the excessively high frequency of physiotherapy sessions (that are not clinically justified) for patients whose treatments are compensated by the CSST (Desjardins October 1st, 2009; Nouvelles TVA October 7th, 2010). To our knowledge, these ethically questionable practices by physiotherapy clinics have not been thoroughly investigated. The lower reimbursement rates paid by the CSST might also encourage discriminative practices between workers'

compensation patients and privately insured patients inside these clinics (Kosny et al. 2011). For example, some clinics simply refuse to treat patients covered by a workers' compensation board because it involves more work for lower fees for the clinic and the treating physiotherapy professionals. This engenders a decrease in accessibility to quality care for patients and encourages discrimination towards this group of patients. One other important ethical challenge faced by PTs is that there is no well-defined or established end point to physiotherapy services (Poulis 2007). For patients with similar conditions, some PTs treat until the patient returns to a prior baseline level, some continue to treat until the patient reaches a functional threshold according to the demands of his or her employment, while others treat until the patient recovers completely and is within normal ranges of strength, motion, mobility or other relevant dimensions. In some cases, the judgement regarding when to end therapy may not be aligned with the recommendations from third-party payers such as workers' compensation boards who sometimes urge PTs to push for a faster RTW, potentially placing the treating therapist in a dilemma if this pressure goes against professional judgement (Poulis 2007).

Although many studies explore issues of QoC from the perspective of workers (Beardwood et al. 2005; Kirsh and McKee 2003; Lippel 2007; MacEachen et al. 2010), very few articles have explored this topic from the point of view of PTs (MacEachen et al. 2010; Pincus et al. 2010), and a recent systematic review on the subject concluded that further research was needed on the experiences of distinct healthcare professionals such as PTs (Kilgour et al. 2014). Exploring PTs' perspectives could help better understand these issues, identify potential obstacles to quality care, and support efforts to improve care for these persons. Given these gaps in knowledge, we conducted a focus group study to obtain a better portrait of QoC in physiotherapy services in the province of Quebec by examining two specific dimensions: the organizational and ethical issues encountered by physiotherapy professionals including PTs and physical rehabilitation therapists (PRTs) (who have a college-level training in contrast to PTs who have a master's-level training) working with CSST patients. The aim of this article is thus to highlight and raise awareness of some QoC issues associated with physiotherapy services for injured workers that are funded by the CSST.

Methods

We selected a focus group approach, as this method allows participants to discuss and brainstorm in a group setting about a particular subject. Focus groups are useful for examining workplace cultures (here the CSST physiotherapy treatment setting) and may facilitate discussion of "taboo" topics (Kitzinger 1994; Krueger and Casey 2009; Mays and Pope 1996). In this study, the interactions during the two focus groups promoted exchange of ideas around physiotherapy services funded by the CSST. These focus groups were organized as part of a larger research program funded by the Canadian Institutes of Health Research (CIHR) and investigating organizational issues and ethical challenges in physiotherapy care paid for by workers' compensation boards in Canada. The two focus groups conducted in this study

represent a first step in exploring organizational and ethical issues that might impact QoC for injured workers supported by the CSST. These results will inform the conduct of a larger study exploring PTs' perceptions of care for injured workers in Canada.

Participants

We recruited PTs and PRTs using purposive and snowball sampling methods, from May to September 2013 (Biernacki and Waldorf 1981; Marshall 1996). First, an invitation e-mail was sent to physiotherapy professionals who were identified through investigator contacts. Then, to recruit more participants in diversified settings, identified participants were asked to suggest other potential participants who might be interested to participate in the focus groups and who might have different experiences, views or opinions related to the phenomenon of interest (snowball sampling). Overall, purposive sampling was used to ensure a diversity of participants, from different clinics and with different experiences as clinicians. To participate, PTs and PRTs had to have at least two years of experience working with CSST patients. Six PTs took part in the first focus group (five females and one male). One participant exclusively held a management position in a public sector physiotherapy department and two participants were working half time as clinicians and half time as managers of private clinics (both were also the owners of their respective clinics). The other three participants worked full time as clinicians, two in the private sector and one in the public sector. There were seven PRTs in the second focus group (five females and two males), working as full-time clinicians in private clinics.

Focus groups

A member of the research team (A.H.) facilitated both focus groups while other researchers observed the sessions and took detailed notes. The main research question guiding the focus groups was: "How do physiotherapy professionals perceive organizational and ethical issues associated with the treatment of injured workers whose care is paid for by the CSST and how might these issues influence QoC for patients?" Different strategies were used to make sure that all participants could voice their own perspectives and experiences during the focus groups (Parker and Tritter 2006). First, a "round table" format was used to allow each participant in turn to share some of their concerns and identify issues they thought were the most important to discuss. An open group discussion followed with the facilitator only intervening to ensure that each participant had the chance to speak on the subject. Periodically, the facilitator proposed new questions to keep the discussion going among the participants. If needed, the facilitator asked the participants to clarify any ideas that were unclear or seemed incomplete. All questions posed by the facilitator were open-ended to encourage the participants to express themselves on each topic. Sufficient time was devoted to each topic so that all the participants had the time to share, discuss and even argue about it. Attention was given to preserve a respectful and productive dynamic and interaction between participants. Three observers were present during the focus groups and provided feedback to the facilitator during the break that occurred halfway through each focus group to help the facilitator

address points that were unclear or had not been discussed in sufficient depth. At the end of the session, participants were asked to express anything they had not had the chance to share during the meeting. Both focus groups lasted 143 minutes with a 15-minute break and were audio-recorded. Recordings were transcribed in their original language (French). Translated verbatim quotations are included in the results section to illustrate aspects of the analysis in relation to the core themes. Quotes presented in this paper were translated from French by a native English-speaking member of the research team.

Analysis

A member of the team (A.H.) performed descriptive and thematic analyses of the focus groups based on the transcripts and supplemented by field notes. Other members of the team reviewed the emerging analysis at several points during its development. Initial inductive coding responded to questions such as “What is going on here?” and “What is this about?” Examples of codes include communication, frustration and end of treatment. The second level of analysis sought to aggregate initial codes through identification of patterns and linkages within each focus group and to compare them with notes taken by the observers. Categories developed for focus group one and two were then compared with each other with the goal of identifying what was common or different between the focus groups. While comparing categories between the transcripts, core themes relating to system organization, ethics and QoC were developed.

Ethical Considerations

This project was reviewed and approved by the Research Ethics Board of the Center for Interdisciplinary Rehabilitation Research of Greater Montreal (CRIR). All participants signed a consent form prior to participating. Personal names and names of clinics or hospitals were removed from the transcripts and participants were assigned pseudonyms.

Results

We identified three core themes related to physiotherapy treatment of CSST patients: (1) systemic factors, (2) complexity in treatment decisions and (3) inequality of care. While there was a high degree of agreement between the two professional groups who participated in the study, some points of divergence were also noted. In particular, several topics which were discussed at length by PTs were not raised by PRT participants. For example, PTs talked about difficulties related to outcome measures used with CSST patients, and that standard measures were often inadequate for this context with several participants suggesting that additional tools were needed, such as psychosocial and fear of movement questionnaires. PTs also expressed dissatisfaction with the financial arrangements between CSST and physiotherapy clinics, suggesting that the rate of reimbursement was insufficient.

Systemic factors

The first theme, *systemic factors*, mostly relates to organizational problems encountered by physiotherapy professionals when caring for injured workers in Quebec. Participants in the focus groups returned frequently to the topic of communication among clinicians and between clinicians and administrators involved in the care of CSST patients. Communication challenges were identified as being the result of structural features of the current system. For example, participants reported that collaboration with the physicians in charge of their patients was hindered, as it was difficult to reach the physicians by telephone and most communication was by written notes (e.g., faxed letters). These communication challenges were seen as having a negative impact on the QoC provided to patients, as they contributed to a lack of coordination in treatment planning and implementation, thus affecting the timeliness and coordination of the intervention. Participants in both focus groups also expressed the view that communication was sometimes impeded when CSST case managers (responsible for payments and follow-up) lacked basic scientific knowledge to understand the therapists' treatment requests or recommendations. Participants described how communication challenges sometimes result in patients receiving mixed messages. The lack of an integrated team approach and multiple communication barriers were viewed as obstacles to treatment planning and as having deleterious effects on patient care. Several participants suggested that interdisciplinary meetings might help clinicians better follow the patient's progression and lead to enhanced care coordination.

Participants also identified variability in the policies established by different CSST jurisdictions in adjoining regions as a source of further confusion. They felt that lack of uniformity in policies made the system more complicated for patients and for therapists alike. For example, some regulations about patients' absences from treatment differed for patients from Montreal or Laval (city just north of Montreal).

Participants described the long hours needed to complete routine CSST paperwork. Considerable time is also spent writing letters to physicians and phoning the employer or the CSST agent to inform them of the patient's progress. A participant stated: "Since there is a third party payer, I, as a clinician, it makes more paperwork to fill out, there is a progress note that has to be done regularly ... thus it makes more paperwork to do." (PT-2). Participants acknowledged that this documentation was implemented for the CSST to monitor the progress of the rehabilitation process. However, they felt that the paperwork system was very inefficient, and doubted that their reports were correctly understood, or always read by CSST case managers. As a result, they expressed that the effort expended on these administrative tasks was excessive and took time away from direct patient care, which they already felt was in short supply: "In my 2.4 patients per hour, I can't see how I can compose letters to the physician; I hardly have time to finish with my patients." (PRT-2).

Participants also expressed that they are not in total control of their patients' rehabilitation care process and that many obstacles can delay their recovery or change the course of treatment. In fact, the patients and their therapists are often waiting for results (e.g.,

radiology or electromyography tests) or specific approval from physicians or employers, which can slow the progression of treatment and cause delays: “Me, I find that they are mostly waiting, the CSST patients. They wait for their appointment for injection, they wait to see the physician, they wait to speak to a case manager ... thus they are not super independent I find. Maybe it’s the system that makes it so.” (PT-4). This situation can lead to significant delays in the process of care for patients. In summary, the examination of systemic factors revealed organizational barriers (e.g., communication challenges between care providers themselves and with the CSST, lack of uniformity in regional policies, administrative burden and delays for specific requests) that can limit the provision of integrated care services and affect the QoC for patients in terms of efficiency, timeliness and patient-centred dimensions of QoC.

Complexity in treatment decisions

The second theme, *complexity in treatment decisions*, encompasses participants’ reflections and frustrations regarding complexity in treatment decisions when treating patients covered by CSST. Participants from both focus groups reflected on differences between treating CSST patients and patients covered by other forms of insurance (e.g., private insurance, automobile insurance). They felt that CSST patients had higher expectations about their recovery and wanted to get back to 100% of their previous capacity before returning to work, even if this was not always feasible. Dealing with these high and sometimes unrealistic expectations was considered challenging by participants. A participant made the following comparison: “This, I find is a difference as I said with the private clientele. The private clientele ... they want to return [to work] even if I know that they are not at 100%, whereas [CSST patients] they expect, say, to be 100% in order to return to their work.” (PT-4). Participants also expressed that CSST patients experience more psychosocial problems and were often categorized as “complex patients.” The fact that the injury happened at work, insecurities related to recovering their abilities, pressure from the employer or the fact that patients sometimes do not like their job may render the treatment context considerably more complex than the physical injury itself. As participants treat a “person” and not only a “physical injury,” they have to take these other factors into consideration when treating their patients. Some felt that their professional training did not adequately prepare them to help patients who experience psychosocial problems. Moreover, participants felt that their patients do not have easy access to specialized psychosocial health professionals when they would benefit from this support. One participant described that for CSST patients: “their entire social and psychological environment is very affected and I feel that the majority of patients are missing the resources at this level...” (PRT-4). Participants in both focus groups expressed the view that there are insufficient resources (e.g., psychologists or social workers) available within the system to help patients progress further during their physiotherapy rehabilitation: “...It is not the majority of clinics that have a mental health approach as well. And maybe that is missing.” (PT-2). Participants suggested that this gap could impede the QoC provided to patients and delay recovery.

Ambiguities associated with decision-making about the course of treatment were also discussed by the participants. Issues around when to end physiotherapy care were a particular concern for many participants, particularly for patients with soft-tissue injuries and chronic pain. Several questions were repeated by participants, including who should make the decision to end treatment (e.g., physicians or PTs), when should treatment be ended (e.g., when patient has reached a plateau) and how the next steps to help the patient should be determined (e.g., surgery, intensive interdisciplinary programs). These ambiguities in patient progression and treatment planning created uncertainty for participants. In sum, participants felt that the injured workers often have high and sometimes unrealistic expectations, and many experience significant psychosocial issues. The participants do not always feel well-equipped to help patients with regards to these dimensions of their care, and experience ambiguity about the course of the rehabilitation process in some cases, which could affect the QoC by potentially impeding the effectiveness of treatment.

Inequality of care

The third theme, *inequality of care*, addresses ethical issues relating to inequality in the provision of care for CSST patients treated in physiotherapy. According to participants, some clinic policies and practices related to CSST patients contribute to unequal care. As mentioned earlier in this text, reimbursement rates for a physiotherapy session are fixed at \$36 by the CSST, while a non-CSST patient typically pays much more in the same clinic (average of \$60) (Fédération des privée de physiothérapie du Québec 2010). Therefore, for financial reasons, some private clinic owners reduce the duration of treatments to CSST patients (e.g., 20 minutes instead of 30 minutes per treatment). Another strategy used to compensate the loss of income associated with the fixed session rate imposed by the CSST is to place these patients under the care of PRTs instead of PTs because these professionals have a lower salary (PRTs have a college degree compared with PTs who now have a postgraduate master's degree). A participant reported that "[at] the clinic where I work, the calculation that they have made, is to have PRTs and they only see patients who are reimbursed by third party payers; they see three patients per hour; me, I see two patients per hour." (PT-2). Additionally, in the current CSST system, the same reimbursement rate applies (\$36) whether the patient is seen for an evaluation (generally lasting one hour and charged as a higher rate than a follow-up session) or for a follow-up treatment session (usually lasting 30 minutes). This \$36 is quite low compared with the fees charged by the clinics to patients for a whole hour evaluation time. Consequently, some owners prefer to split the evaluation in two for financial reasons. Thus, unlike non-CSST patients who receive a first evaluation in a one-hour session, in some clinics, CSST patients are evaluated in two separate sessions of 30 minutes. However, participants felt that this practice can impede the establishment of a good therapeutic relation and lead to a less effective evaluation of the patients' condition. Finally, participants also mentioned that in some clinics, CSST patients who are off work are only given appointments in the middle of the day because early morning and evening times are reserved for "active" workers.

In sum, many clinic-specific rules relating to physiotherapy care of CSST patients do not seem to encourage the best care possible and differ from the care offered to other patients in the same clinics. One participant summarized the situation: “What the [CSST] patient needs is not exactly what he receives. It’s red tape politics you know.” (PT-3). Participants also expressed many negative emotions during the focus groups. Terms like “frustration,” “discouragement” and “exhaustion” were used numerous times. Participants expressed these sentiments usually in relation to their sense of unjust practices and policies towards CSST patients. These concerns are reflected by a participant who described this feeling: “...listen, at times I would like to switch and be a lawyer to defend the cases of the CSST. Ah I’d be happy!” (PRT-3). The theme of inequality of care encompasses a range of ways in which CSST patients’ care is structured or provided differently than for other patients. Participants expressed that many clinic and CSST policies seem unjust and unfavourable in regards to CSST patients. Participants clearly expressed that these features lead to ethical tensions, and are associated with negative emotions and feelings of frustration. Inequality for CSST patients’ treatments might diminish the QoC they received and could also lead to stigmatization of this clientele and create ethical distress for professionals.

Discussion

Many important issues were identified in this study that provide an insight into physiotherapy services reimbursed by the CSST. Even though this study focused on the Quebec workers’ compensation system, these findings offer an important point of comparison for other Canadian provinces or other nations.

The study findings present some similarities with qualitative results from a systematic review of international studies on healthcare providers involved in the care of injured workers (Kilgour et al. 2014). These similarities relate to numerous factors such as the frustration of healthcare professionals when they experience a disconnect between their recommendations and what the insurer approves, challenges in communication with some claims managers, lower fees paid by workers’ compensation boards to healthcare professionals, administrative burden and increased workload when dealing with the workers’ compensation system and healthcare professionals’ lack of knowledge of the system that creates uncertainty about their role in it.

Many organizational or systemic factors were found as potentially impeding diverse dimensions of QoC. For example, the findings suggest that the communication modalities established between the different stakeholders in the care of CSST patients (such as three-week reports) are far from optimal, reducing the timeliness and efficiency of care for potential beneficiaries. Effective communication, both among caregivers and between caregivers and patients, is critical for high-quality care (Institute of Medicine and Committee on Quality of Health Care in America 2001). From the perspective of the PTs and PRTs, documentation and forms used in the CSST system are inefficient and do not serve the purpose well of

promoting clear communication. Concern about excessive time spent on administrative paperwork and the effects of poor communication between different stakeholders are also reported by professionals involved in the care of injured workers in other settings (Kosny et al. 2011). For example, Wickizer and colleagues report that workers' compensation systems impose significant administrative burdens on physicians in the US in the form of billing requirements, referral approval procedures and utilization management processes (Wickizer et al. 2001). These physicians also described how aspects of the system were unresponsive to the needs of injured workers (Wickizer et al. 2001). In another study, MacEachen et al. (2010) examined the experiences of different healthcare professionals (chiropractors, occupational health physicians, PTs) in Ontario, Canada, regarding workers' compensation system. They identified QoC issues such as ineffective procedures for communication and a lack of collaboration between healthcare providers, leading to a "toxic dose of system problems" (MacEachen et al. 2010).

Participants in our study also emphasized the importance of psychosocial factors in the treatment of CSST patients. However, the current system does not facilitate the integration of other professionals to work in an interdisciplinary fashion in the patients' rehabilitation, despite the fact that consideration of psychosocial factors is an important determinant in injured workers' RTW processes (Franché and Krause 2002). Participants in this study also expressed their lack of training and the difficulties they experienced in addressing psychosocial issues with their patients. This situation could contribute to a reduction in effectiveness of interventions for patients when relevant psychosocial factors remain unaddressed and unmet during the rehabilitation process, thereby reducing QoC (Soklaridis et al. 2010).

Studies about RTW after work-related injuries also emphasize the importance of integrating the employer in the process (Durand and Loisel 2001; Franché et al. 2005; Loisel and Anema 2013). However, participants rarely described the employer as a member of the rehabilitation team, and linkage with the workplace does not seem to be supported in the current system. In Quebec, the PTs never speak nor communicate with the injured worker's employer to respect confidentiality. This renders the potential adjustments for RTW plans much harder to orchestrate for the healthcare providers such as physicians and PTs. Quebec differs from other Canadian provinces on this matter. PTs in British Columbia and Ontario now communicate by phone or by letter with the employer, with their patient consent, to facilitate the RTW process. The impact of this lack of contact between healthcare providers and employers in Quebec should be investigated in greater depth in future studies.

Finally, the negative emotions expressed by participants with regards to the significant differences between the care provided to CSST patients compared with "other patients" illustrate the impact of lack of equity in the provision of care on clinicians. PT professionals are well-aware that the system and their clinic rules contribute to inequities, a situation which sometimes leads to feelings of ethical distress for them. Equitable care is compromised when quality varies based on the source of payment of treatments. These differences include,

amongst others, structure and duration of evaluations, the likelihood of being treated by PRTs (rather than PTs) and the duration of individual treatment sessions.

In terms of policy change, many aspects of the results could orient future exploration of the impact of the CSST system on the QoC of injured workers, both for internal policies of private clinics and for CSST policies. First, private physiotherapy clinics should consider the impacts on patients' QoC of internal policies they have implemented. Depending on the PTs and their internal clinic policies, the length and frequency of treatment for patients covered by the CSST can vary greatly. For example, for financial reasons (i.e., as the fees-for-service paid by the CSST to physiotherapy clinics are lower than those paid by patients out-of-pocket or through their private insurance companies), some clinics choose to treat patients covered by the CSST for 20-minute sessions, instead of the provincial average of 30 minutes offered to non-CSST patients. Decreased treatment time or restrictions in scheduling are practices that could encourage stigmatization of patients and increase inequity in care. These internal policies also led to the expression of negative emotions in participants having to deal on a regular basis with these disparities. The FPPPQ, a federation of private physiotherapy clinics in Quebec, could serve as a facilitator to help clinics implement internal policies that would have positive impacts on the QoC for CSST patients. Second, policy revisions of the structure and mechanisms of communication between stakeholders involved in the rehabilitation process should also be examined by the CSST. It would be valuable, for example, for the CSST to develop a new pilot project aimed at enhancing communication between physiotherapy professionals, the physician and employers to facilitate the RTW process. Moreover, some CSST policies could be developed to support a more coordinated decision framework between physicians, PTs and patients throughout the rehabilitation process. Finally, the availability of external and prompt psychosocial resources, such as psychologists or social workers, during the rehabilitation phase could also facilitate the RTW and healing process for patients, as well as supporting PTs in their management of these patients. However, before suggesting specific changes to actual policy, a larger study exploring these issues with physiotherapy professionals and other stakeholders is warranted.

Limitations

This exploratory study aimed to illuminate key QoC organizational and ethical issues encountered by PTs and PRTs treating injured workers compensated by the CSST. The results reflect how these issues were perceived and experienced by the 13 participants who took part in two focus group sessions, and may not reflect all issues related to QoC in the physiotherapy domain for CSST patients. Another limitation is that all participants worked in an urban region (greater Montreal) and the results may be less applicable to care in rural regions (Lamarche et al. 2011). Finally, the participants are themselves interested by the CSST system, and their insights might not reflect the variety of perspectives among PTs and PRTs

who treat injured workers. We propose that future studies on this topic use a larger sample of physiotherapy professionals in different regions of Quebec and other Canadian provinces. Other measures of QoC using quantitative methods could also be used to investigate other dimensions of this phenomenon.

Conclusion

This exploratory study suggests that CSST patients might not always be provided with optimal treatments owing to systemic barriers to adequate care. Because CSST patients often have complex needs requiring interdisciplinary care, the establishment of treatment plans can be challenging. This task can be complicated further by the lack of coordination and effective communication between the many stakeholders involved. Even if PTs and PRTs strive to give CSST patients the best possible care, when compared with other patients, there appears to be differences with respect to the type and quality of services offered, raising concerns about equity of care. These differences might partially be related to the model of financial reimbursement. Renewed and productive dialogue between the CSST and PTs is required to improve the different dimensions of patient care and to establish a greater sense of partnership. Work-related musculoskeletal physical disabilities are a significant burden for society, through treatment costs and loss of work productivity. They can also have a devastating impact on the quality of life of injured workers. Addressing systemic issues that limit QoC is a pressing need.

Acknowledgements

The authors wish to thank members of a journal club at McGill University and Elaine Lamarre Leroux for their precious comments on an earlier version of this manuscript. Anne Hudon is supported by a doctoral fellowship from the Fond de recherche du Québec-Santé (FRQS) and from the MENTOR program in collaboration with the Canadian Institutes of Health Research (CIHR) and the Quebec Research Rehabilitation Network (REPAR). Maude Laliberté holds a doctoral fellowship from FRQS. Matthew Hunt and Debbie Feldman are supported by salary awards from the FRQS. Financial support for this work was also received from the CIHR and the Dominion of Canada General Insurance administered by the Physiotherapy Foundation of Canada (CIHR funding number of reference: EOG-120255).

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