Return-to-Work Planning in Family Medicine: Practical WSIB Considerations

PANELISTS

Dr. Aaron Thompson

WITH

Dr. Stephanie Zhou • Dr. Carrie Bernard

Ontario College of Family Physicians — Thriving Family Physicians in a Healthy Ontario

Family & Community Medicine, University of Toronto | Mental Health and Addictions

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Your name,
Your community,
Your X (Twitter) handle

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Send us an email with your name & topic(s) of interest to
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Your Panelists: Disclosures

Dr. Aaron Thompson

Relationships with financial sponsors (including honoraria):

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- Chair, Royal College of Physicians and Surgeons of Canada (RCPSC), Specialty Committee Occupational Medicine
- Chief Medical Officer- Workplace Safety and Insurance Board (WSIB), Ontario
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Relationships with financial sponsors (including honoraria):

•Ontario College of Family Physicians – Practising Well Scientific Planning Committee
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•Department of Family and Community Medicine (University of Toronto), Dept of Medical Imaging, Dept of Ob/Gyn for practice management lectures
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Dr. Carrie Bernard

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- FPME – Medical Editor

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- College of Family Physicians of Canada – Past President of the Board of Directors

Mitigating Bias

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N/A

Mitigating potential bias

The Scientific Planning Committee (SPC) has control over the choice of topics and speakers.

Content has been developed according to the standards and expectations of the Mainpro+ certification program.

The program content was reviewed by the SPC.

Practising Well Self-Learning Program

The Practising Well CoP is certified for self-learning credits!

Earn **1-credit-per-hour** for reviewing the recording and resources from **past CoP sessions**. The self-learning program is certified for up to 63 Mainpro+ credits.

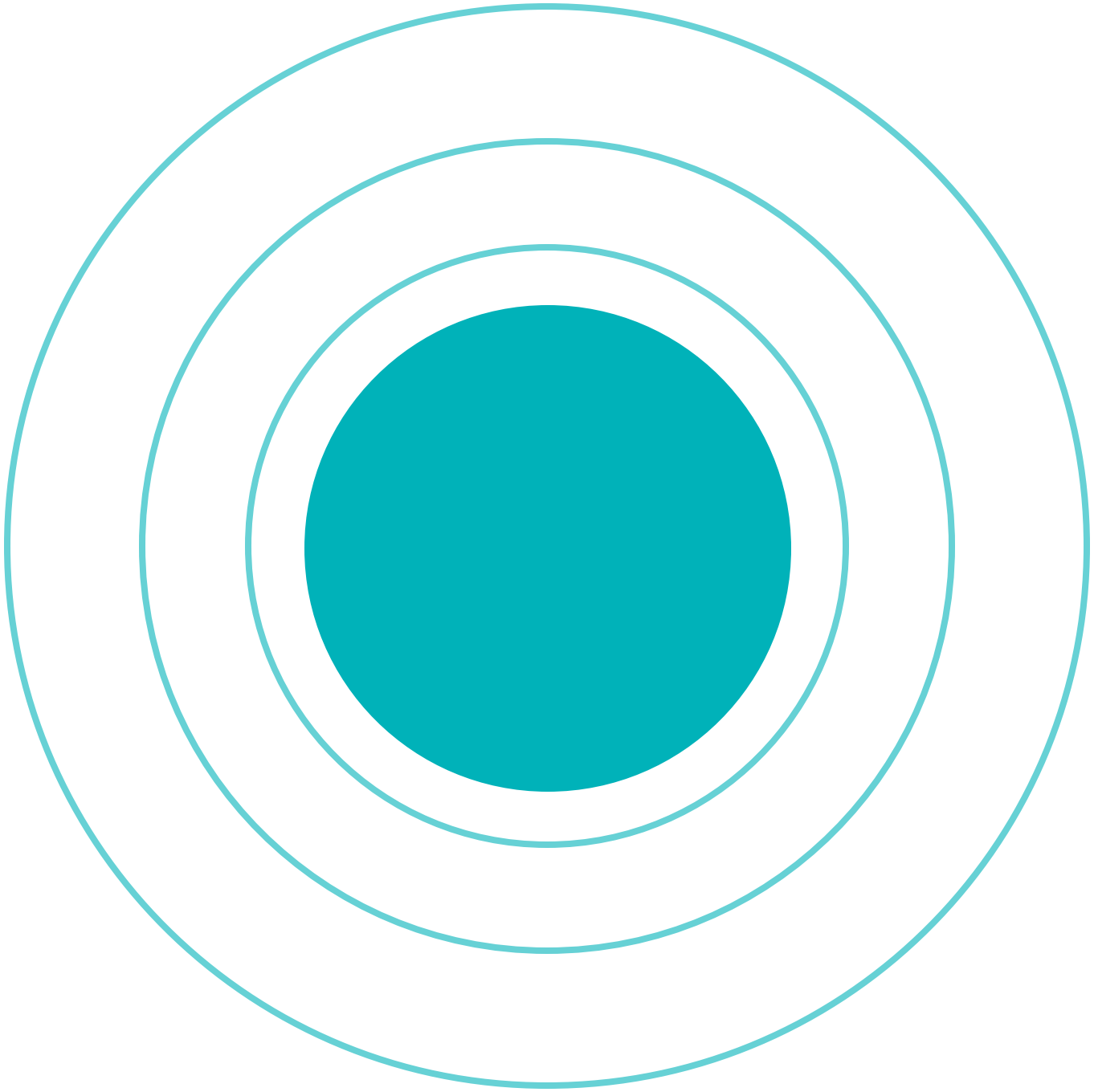
Learn More and Participate

Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

The OCFP and DFCM recognizes that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. The OCFP and DFCM respects that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.



Your Panelists

Dr. Aaron Thompson

Return-to-Work Planning in Family Medicine: Practical WSIB Considerations

TEMERTY FACULTY OF MEDICINE
UNIVERSITY OF TORONTO

Temerty Medicine

Return-to-Work Planning in Family Medicine: Practical Considerations

Aaron Thompson, MD, MPH, FRCPC
Associate Professor, Faculty of Medicine, University of Toronto
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Chief Medical Officer, WSIB

Objectives

1. Describe determinants of work disability
2. Explain why remaining at work in accommodated role or early return to work in some capacity improves outcomes
3. Apply a structured approach to planning return to work
4. Have effective conversations about return to work with your patients
5. Effectively complete WSIB and other forms related to work

Andy's predicament

"It all started when I woke up with severe back pain. The doc gave me tablets and told me to rest and stay off work - but I didn't get any better. I was sent for x-rays, which showed degeneration. Then I had to wait around to get treatment. The therapist said it was my job that caused it, so I shouldn't go back till I was fully fit. By that stage I started to get really worried - and feeling down. The family won't let me do anything, so I don't get out much. The people at work haven't been in touch, so I don't know what's happening about me getting back. People said I should put in a claim: the solicitor sent me to a specialist so it must be serious. This whole ongoing saga has just taken over my life - all I wanted was a bit of help...."

Kim Burton. Identifying and tackling obstacles to return to work. 2014. Accessed at http://www.nhshealthatwork.co.uk/images/library/files/2014%20conference/KIM_BURTON_PRESENTATION.pdf

What causes work disability?

Let's start with a question

What percentage of disability is typically explained by pain?

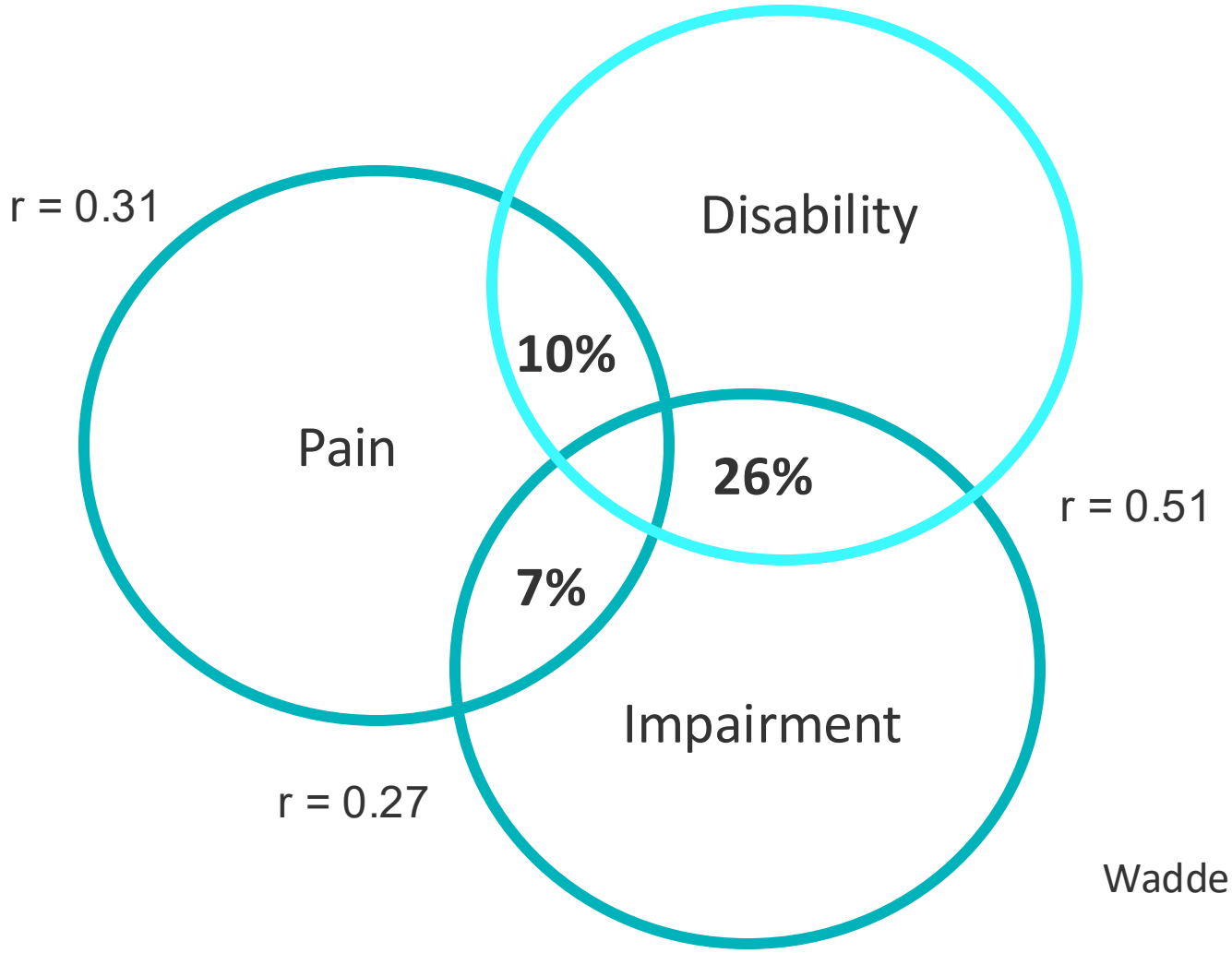
a) 85%

b) 50%

c) 30%

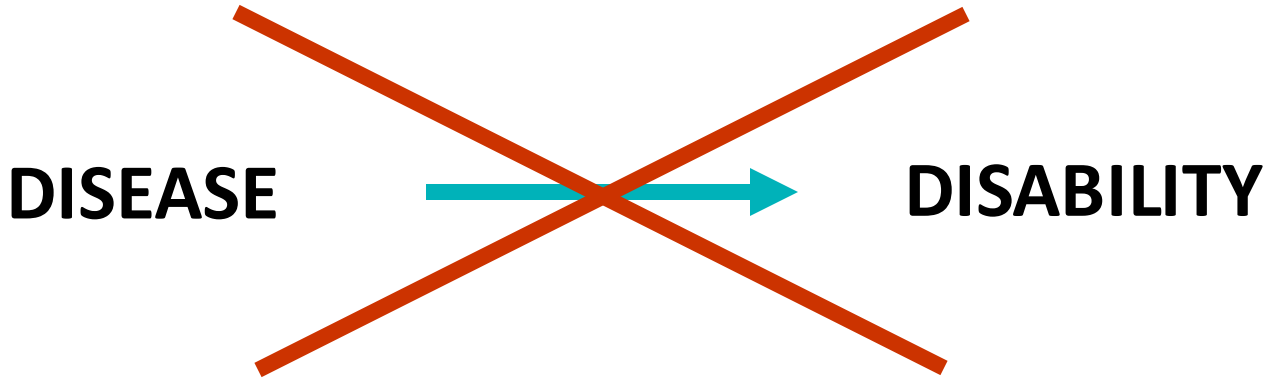
d) 10%

Percentage of disability explained by pain and measurable impairments



Waddell et al. 2002

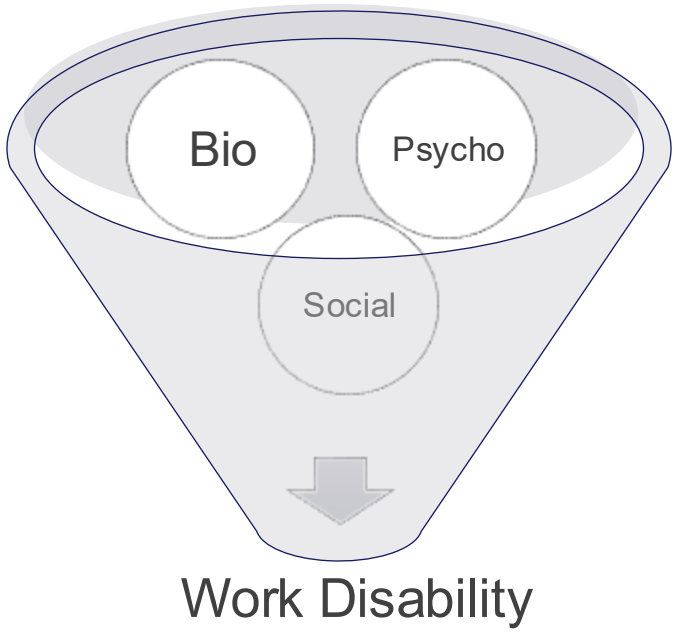
Disease / disability



- Evidence indicates the medical model for disability management (“fix the injury and the person will get back to work”) is not effective.
- There are too many other factors that cause disability, and most increase with duration of time away from work.

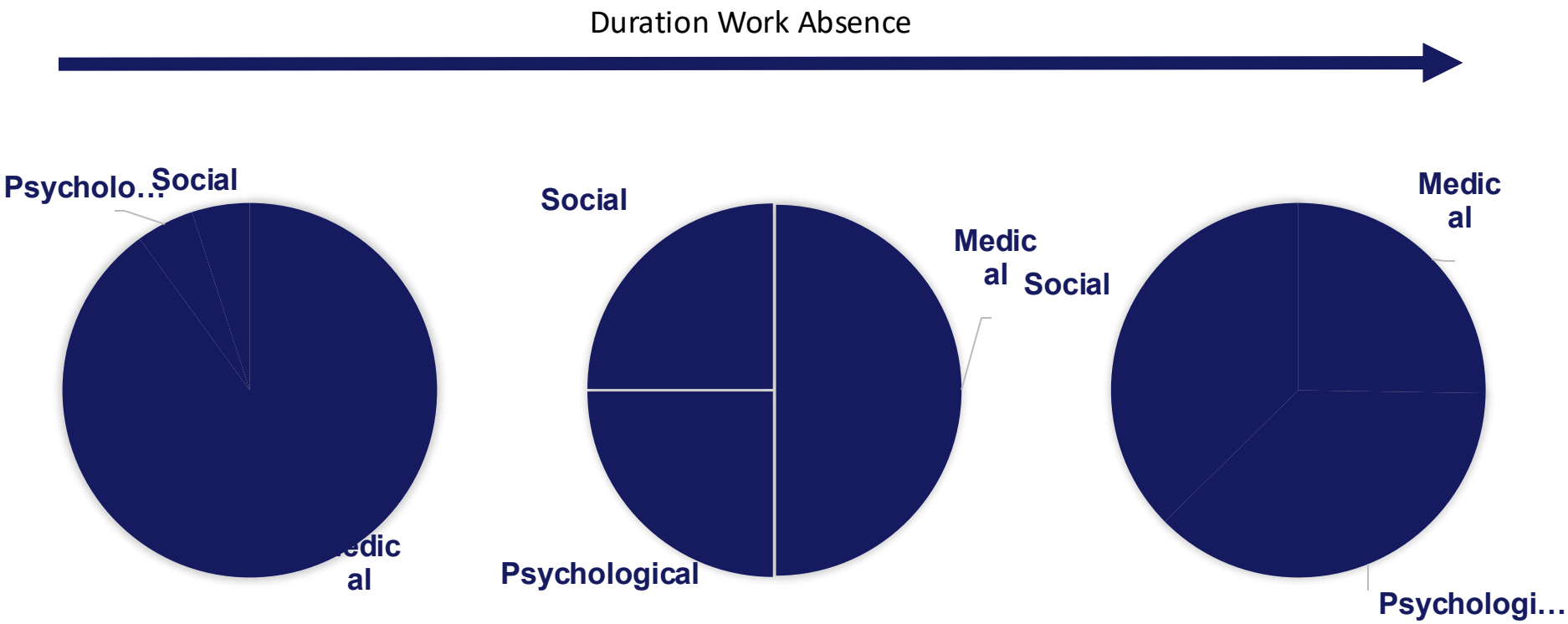
Determinants of Work Disability

- **Biological factors**
  - e.g. medical status, physical capacity
- **Psychological factors**
  - e.g. fear, anxiety, motivation, depression
- **Social factors**
  - e.g. work environment, compensation system



Slide used with permission of Dr. Patrick Loisel

Determinants of Work Disability Change over Time



Why is understanding these causes of work disability and how they change overtime important for us when we are seeing patients who are wondering about return to work?

Another question

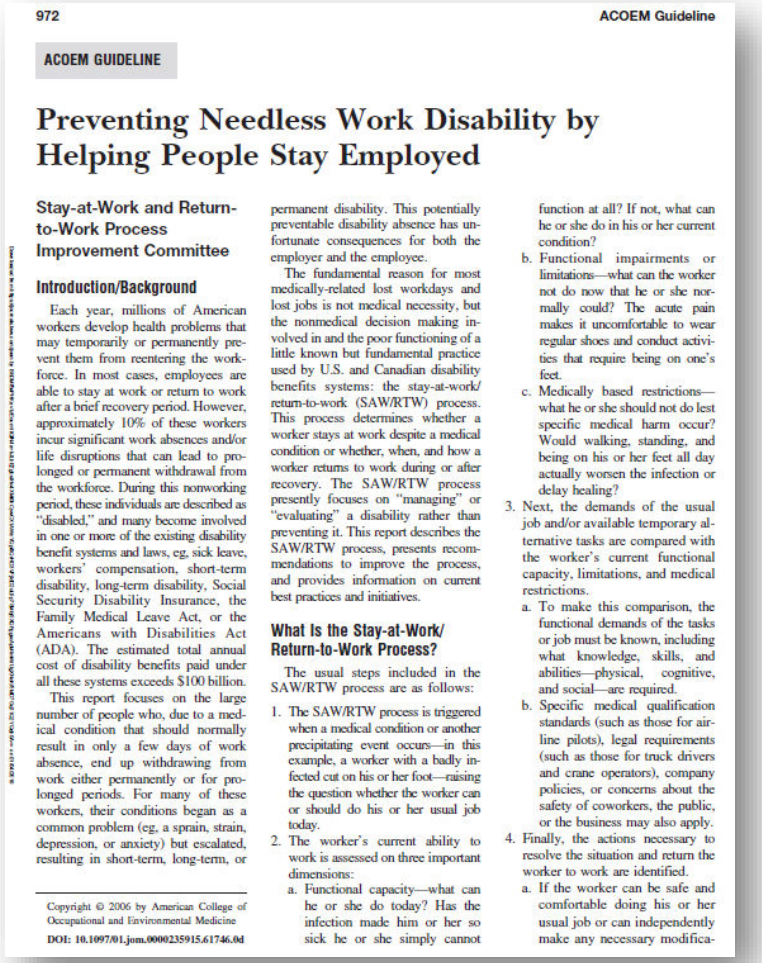
What is the likelihood a patient will return to gainful employment after 6 months of being off work?

a) 90%

b) 75%

c) 50%

d) 10%



ACOEM GUIDELINE

Preventing Needless Work Disability by Helping People Stay Employed

Stay-at-Work and Return-to-Work Process Improvement Committee

Introduction/Background

Each year, millions of American workers develop health problems that may temporarily or permanently prevent them from reentering the workforce. In most cases, employees are able to stay at work or return to work after a brief recovery period. However, approximately 10% of these workers incur significant work absences and/or life disruptions that can lead to prolonged or permanent withdrawal from the workforce. During this nonworking period, these individuals are described as "disabled," and many become involved in one or more of the existing disability benefit systems and laws, eg, sick leave, workers' compensation, short-term disability, long-term disability, Social Security Disability Insurance, the Family Medical Leave Act, or the Americans with Disabilities Act (ADA). The estimated total annual cost of disability benefits paid under all these systems exceeds $100 billion.

This report focuses on the large number of people who, due to a medical condition that should normally result in only a few days of work absence, end up withdrawing from work either permanently or for prolonged periods. For many of these workers, their conditions began as a common problem (eg, a sprain, strain, depression, or anxiety) but escalated, resulting in short-term, long-term, or permanent disability. This potentially preventable disability absence has unfortunate consequences for both the employer and the employee.

The fundamental reason for most medically-related lost workdays and lost jobs is not medical necessity, but the nonmedical decision making involved in and the poor functioning of a little known but fundamental practice used by U.S. and Canadian disability benefits systems: the stay-at-work/return-to-work (SAW/RTW) process. This process determines whether a worker stays at work despite a medical condition or whether, when, and how a worker returns to work during or after recovery. The SAW/RTW process presently focuses on "managing" or "evaluating" a disability rather than preventing it. This report describes the SAW/RTW process, presents recommendations to improve the process, and provides information on current best practices and initiatives.

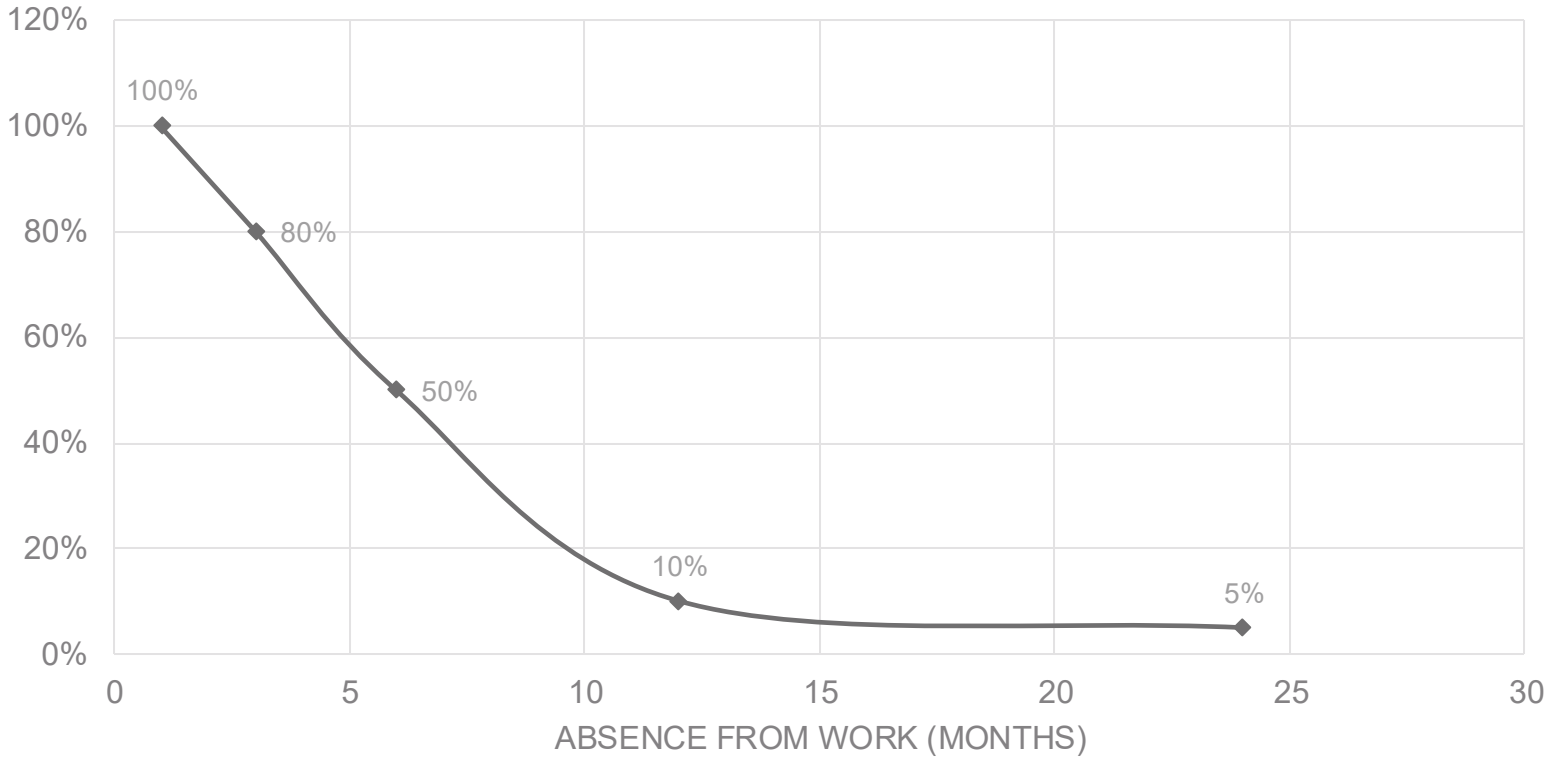
What Is the Stay-at-Work/Return-to-Work Process?

The usual steps included in the SAW/RTW process are as follows:

1. The SAW/RTW process is triggered when a medical condition or another precipitating event occurs—in this example, a worker with a badly infected cut on his or her foot—raising the question whether the worker can or should do his or her usual job today.
2. The worker's current ability to work is assessed on three important dimensions:
   a. Functional capacity—what can he or she do today? Has the infection made him or her so sick he or she simply cannot function at all? If not, what can he or she do in his or her current condition?
   b. Functional impairments or limitations—what can the worker not do now that he or she normally could? The acute pain makes it uncomfortable to wear regular shoes and conduct activities that require being on one's feet.
   c. Medically based restrictions—what he or she should not do lest specific medical harm occur? Would walking, standing, and being on his or her feet all day actually worsen the infection or delay healing?
3. Next, the demands of the usual job and/or available temporary alternative tasks are compared with the worker's current functional capacity, limitations, and medical restrictions.
   a. To make this comparison, the functional demands of the tasks or job must be known, including what knowledge, skills, and abilities—physical, cognitive, and social—are required.
   b. Specific medical qualification standards (such as those for airline pilots), legal requirements (such as those for truck drivers and crane operators), company policies, or concerns about the safety of coworkers, the public, or the business may also apply.
4. Finally, the actions necessary to resolve the situation and return the worker to work are identified.
   a. If the worker can be safe and comfortable doing his or her usual job or can independently make any necessary modifica-

DOI: 10.1097/01.jom.0000235915.61746.0d

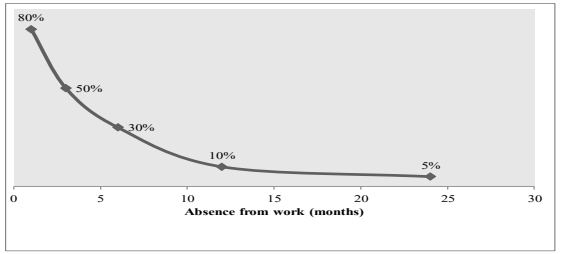
"The odds for return to full employment drop to 50/50 after 6 months of absence."



References:

1. Preventing needless work disability by helping people stay employed. J Occup Environ Med. 2006 Sep;48(9):972-87.
2. Texas Dept. of Insurance, Workers' Compensation Research and Evaluation Group; "Return to work outcomes for Texas injured workers"; 2007.
3. Infante-Rivard; "Prognostic factors for return to work after a first compensated episode of back pain"; Occup Environ Med 1996.
4. Waddell G, Burton AK, Main CJ. 2003. Screening to identify people at risk of long-term incapacity for work. Royal Society of Medicine Press, London.
5. Waddell G, Burton AK. Is work good for your health and well-being? London (UK): The Stationery Office; 2006.

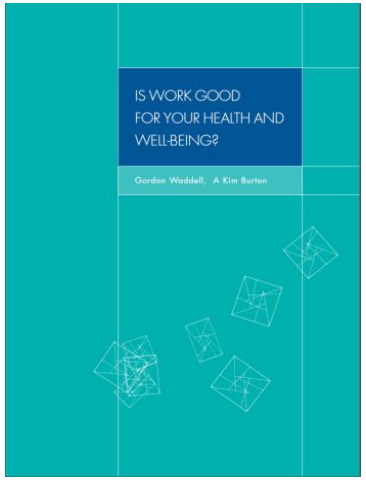
Reasons likelihood of RTW decreases with prolonged absence from work



- **Medical Selection**
- More severe the injury, the higher the likelihood of prolonged or permanent disability.
- Complex injuries have longer durations of disability, and they also have lower likelihood of ever returning to work

- **Social Selection**
- Being off work itself, regardless of injury type or severity, is an independent cause of increasing work disability.
- Psychosocial factors that develop when a person is off work become important barriers to return to work.
- Therefore, with increasing time off work, there is an increase in psychosocial barriers to return to work, and this leads to lower likelihood of ever returning to work with increasing time off work.

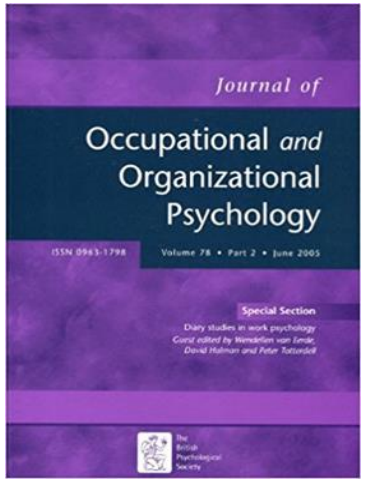
Waddell G, Burton A. Is work good for your health and well-being? London, UK: The Stationery Office; 2006.



53 longitudinal studies: health impact of re-employment (RTW):

- Re-employment improved measures of general health and well being; self esteem, self-rated health, self-satisfaction, physical health.
- Re-employment improved psychological and psychiatric morbidity.
- Social selection vs. medical selection?
  - "Balance of evidence indicates health improvements are to a large extent the direct consequence of re-employment."

Murphy, G. C. and Athanasou, J. A. (1999), The effect of unemployment on mental health. Journal of Occupational and Organizational Psychology, 72: 83-99.



Systematic review: 16 longitudinal studies mental effects unemployment:

- Outcomes - general mental well-being, psychological distress and/or depressive symptoms (e.g. General Health Questionnaire GHQ).
- 7 studies (1509 subjects total) showed re-employment had a positive effect on mental health.
- Findings hold even for severe mental health conditions

Social Selection Mechanisms

- Fear-Avoidance
- Adjustment to new schedule and routines
- Real/perceived conflict with employer or co-workers
- Loss of work-role centrality
- Adverse impact on mental health (poor core self-evaluation, stronger stress appraisal, social undermining from others)

Policy Studies Institute

“Phases model” - time course of adverse mental health effects with worklessness

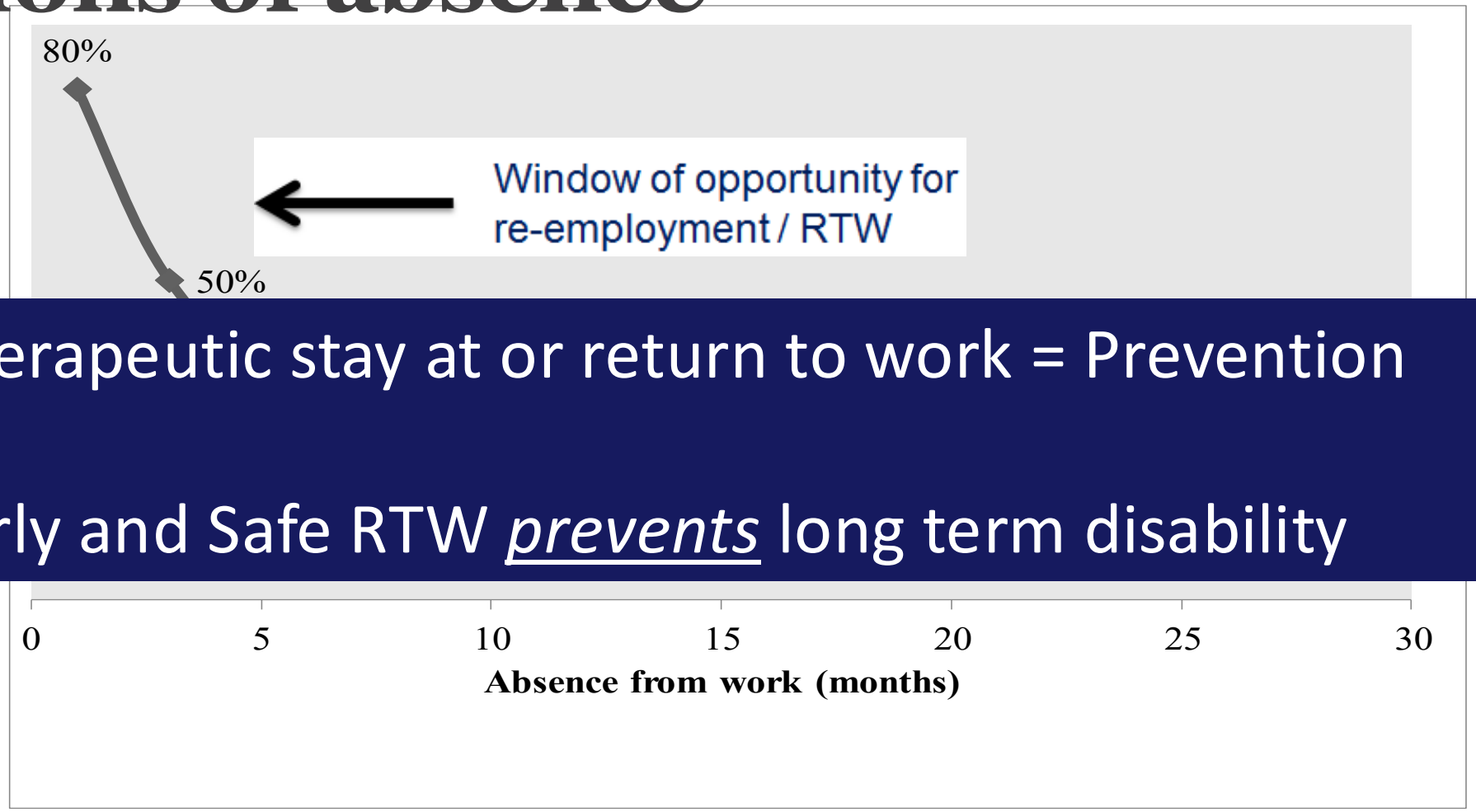
Lakey, J., Mukherjee, A., White, M. (2001)

Three stages:

- optimistic activity
- increasing distress
- fatalism and apathy

← Window of opportunity for RTW

Likelihood of RTW after increasing durations of absence



Therapeutic stay at or return to work = Prevention

Early and Safe RTW *prevents* long term disability

References:

1. Texas Dept. of Insurance, Workers' Compensation Research and Evaluation Group; "Return to work outcomes for Texas injured workers"; 2007.
2. Infante-Rivard; "Prognostic factors for return to work after a first compensated episode of back pain"; Occup Environ Med 1996.
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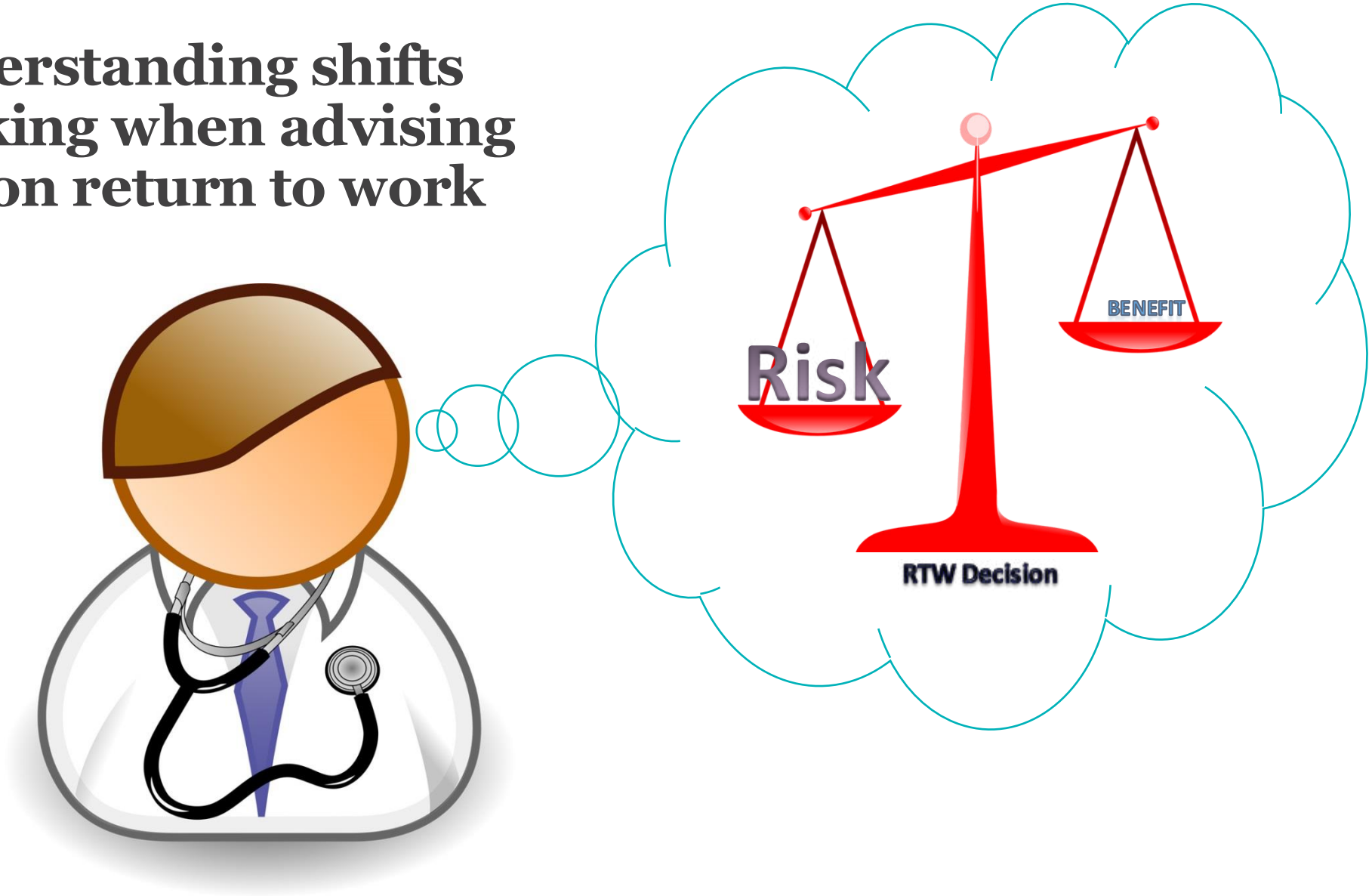
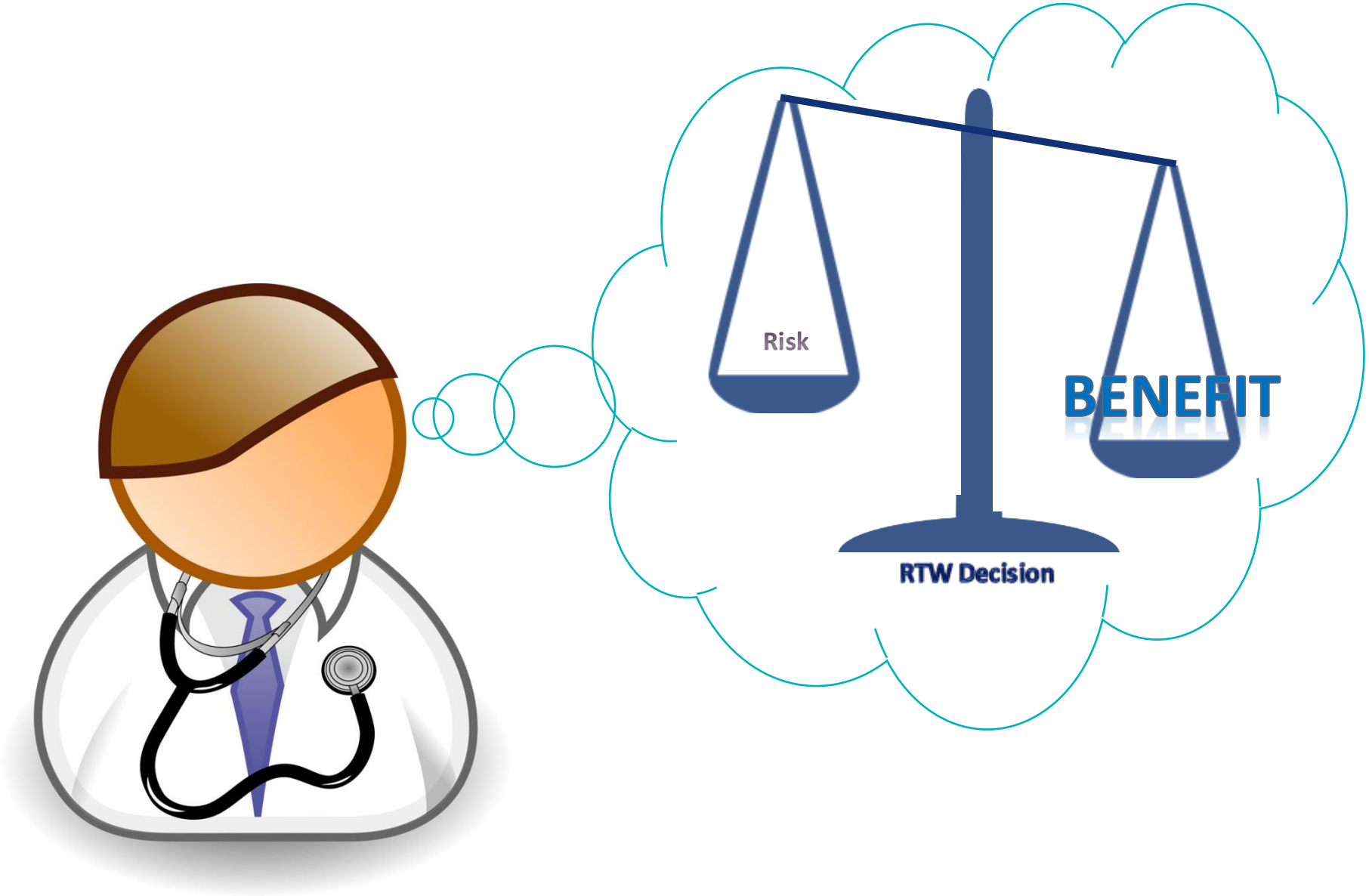
This understanding shifts our thinking when advising patients on return to work




Risk
BENEFIT
RTW Decision

ASSOCIATION MÉDICALE CANADIENNE | CANADIAN MEDICAL ASSOCIATION

CMA POLICY

THE TREATING PHYSICIAN'S ROLE IN HELPING PATIENTS RETURN TO WORK AFTER AN ILLNESS OR INJURY

(UPDATE 2013)

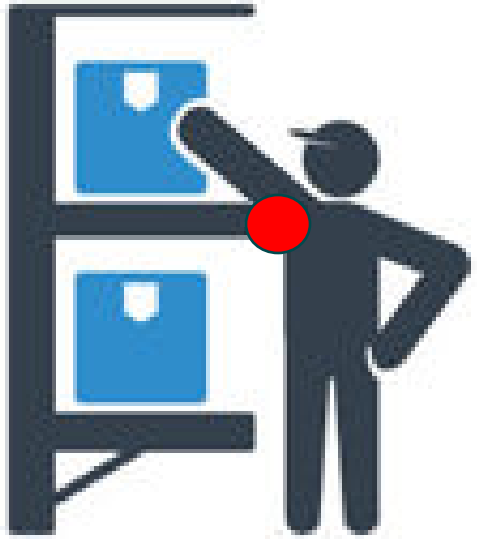
Executive Summary

This policy addresses the role of the treating physician in assisting their patients return to work after an illness or injury. The treating physician's role is to diagnose and treat the illness or injury, to advise and support the patient, to provide and communicate appropriate information to the patient and the employer, and to work closely with other involved health care professionals to facilitate the patient's safe and timely return to the most productive employment possible. Fulfilling this role requires the treating physician to understand the patient's roles in the family and the workplace. Furthermore, it requires the treating physician to recognize and support the employee-employer relationship and the primary importance of this relationship in the return to work. Finally, it requires the treating physician to have a good understanding of the potential roles of a return-to-work coordinator and of other health care professionals and employment personnel in assisting and promoting the return to work.

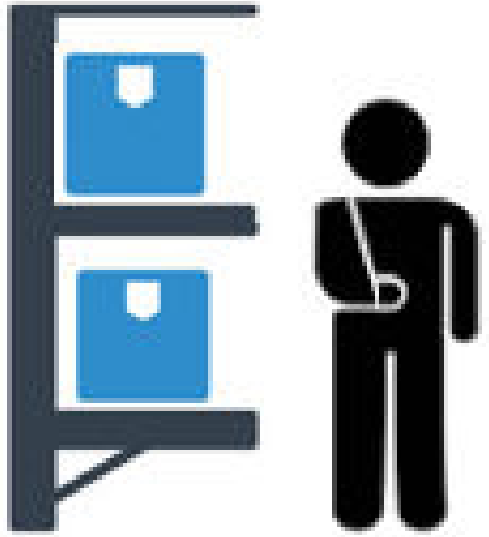
How do we ensure our patient is SAFE and SUCCESSFUL if they stay at or return to work?


Rx
Return to work:
• Restrictions
• Limitations
• Abilities

Restrictions vs Limitations – Why is it important to differentiate these two concepts?



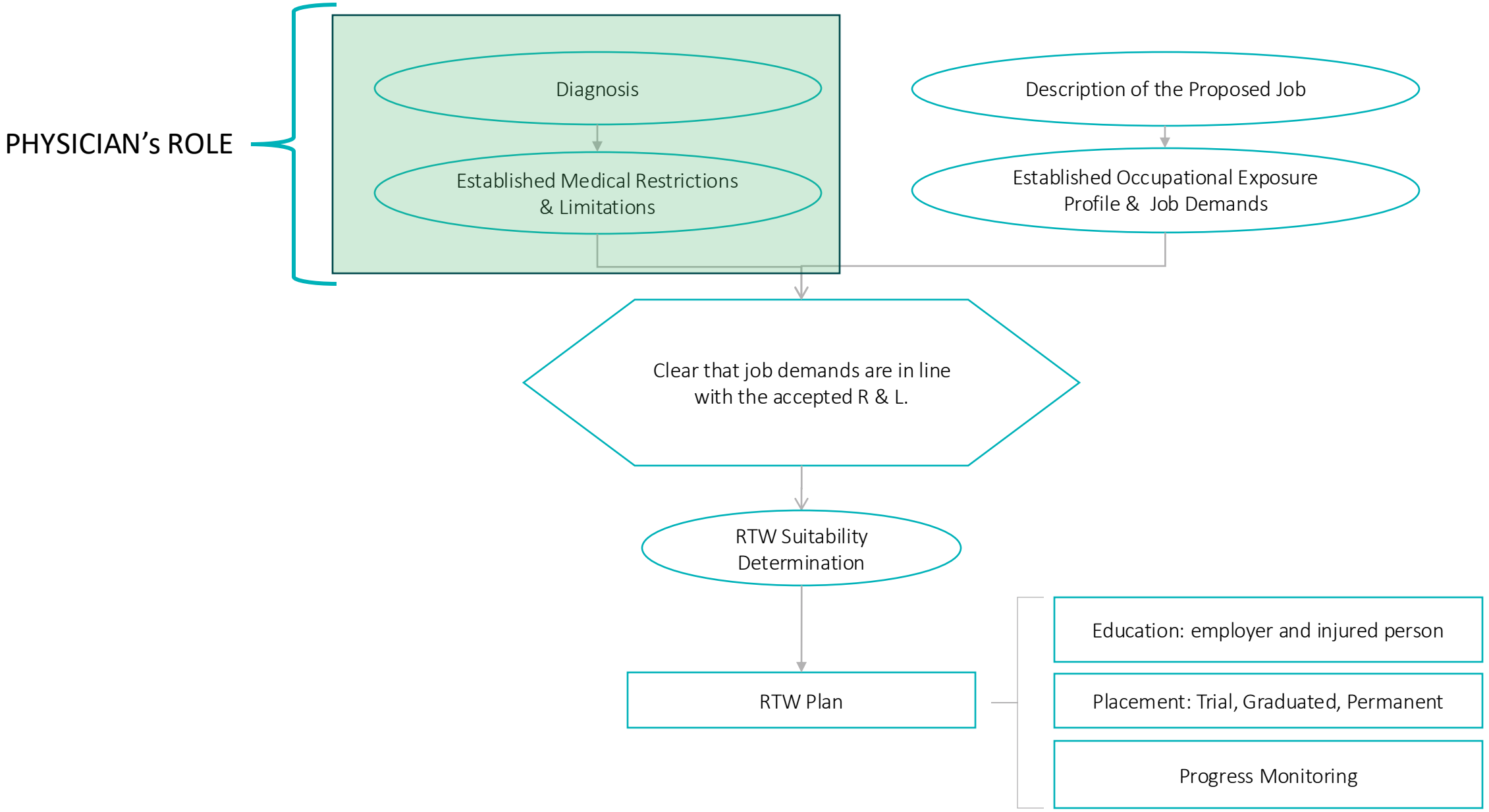
Clear Restrictions ensure SAFETY



Clear Limitations ensure SUCCESS

So how does my role as physician fit into the Stay at Work / Return to Work Process?

RTW Process


PHYSICIAN's ROLE
Diagnosis
Established Medical Restrictions & Limitations
Description of the Proposed Job
Established Occupational Exposure Profile & Job Demands
Clear that job demands are in line with the accepted R & L.
RTW Suitability Determination
RTW Plan
Education: employer and injured person
Placement: Trial, Graduated, Permanent
Progress Monitoring

How do we help our patient understand our role and the return to work process?

Conversations on RTW

Conversations about work with your patient

GOAL 1 – Understand and then address the persons concerns about return to work (fear of reinjury, concern they will not be able to successfully do the work)

GOAL 2 - Explain your role as their physician in the process and how this differs from the employer's role.

Conversations about work with your patient

Step 1 – Ask about then re-enforce what they have said is meaningful for them about their work

E.g. "*You indicated that you feel a sense of accomplishment when you are at work, and you like spending time with co-workers – these are some of the factors that evidence indicates help people in their recovery*"

Step 2 - Ask them why they currently cannot return to work

People will usually say one of two things:

I am worried about re-injury and/or

I can't do my job (physically or cognitively)

Step 3 - Explain your role as per the CMA and CHRC – My role is to document ***restrictions*** to keep you safe, and ***limitations*** to make sure you are only assigned tasks they can successfully complete.

E.g. "*You said you're scared you may reinjure yourself and will not be able to do the tasks assigned. It is normal to worry about this. My job as your physician is to document very clear medical restrictions (tasks you should not do) to keep you safe, and limitations (tasks you physically or mentally are unable to perform) to make sure you are only given tasks you can successfully do. You employer has a duty to accommodate these, and it is their role (not me at your physician) on how they accommodate you. But they must follow the restrictions and limitations.*"

Let’s do another case study

- JH is a 45-year-old man who works as a painter at a mill. He presents complaining of severe low back pain radiating to his right leg. He had a number of episodes of minor back pain in the past, which improved with NSAIDS and a few days of cautious movement.
- His back had been “a little sore” and “kind of stiff” for a few days, and then yesterday, when he jumped off the bottom of a ladder at work, he experienced a sudden increase in pain. He has pain down the back of his right leg to his ankle.
- He was able to complete his shift, although he had a lot of pain. He wants to get back to work tonight and is requesting “pain killers” so he can do so.
- He has not reported this as a WSIB case because it is a “lot of paperwork”
- In addition, he states that if he loses time, his shift loses the bonus for “no lost time.”
- He indicates that he’ll “have to go back to his regular job, as there is nothing else for him to do at the mill.”
- On examination, he has slightly decreased lumbar lordosis and is about 50 lbs overweight. Lumbar flexion is decreased to about 30 degrees and extension to about 10 degrees. He has diminished lateral bending, but rotation is normal. His reflexes are 2+ bilaterally at the patella and Achilles sites, and he has normal sensation. He has a positive SLR at 30 degrees. Heel and toe walking are painful but his strength appears normal. He is unable to do a deep knee bend because of pain.

1. Do you fill out a WSIB form? Are you required to? How do you advise him?
2. If you do initiate a WSIB claim, what other considerations are there for the empl
3. Complete the WSIB form(s) for him.
4. How do WSIB and the employer deal with claims that are not entirely work related?
5. What treatment would you recommend for him?
6. If he does miss time, will it matter to the employee if he is on WSIB or short-term disability?
7. What do you think of his concern regarding his bonus? Do his employer and WSIB share this concern?
8. Is there a role for physiotherapy in this case? If so, when would you involve them? Does it make a difference to physio if it is a WSIB case or not?
9. The occupational health nurse calls you the next day regarding return to work. Do you need permission to talk to them? What if the WSIB claims adjudicator calls you?
10. What is the employer's duty to accommodate a patient after a workplace injury?

What do you recommend regarding **return to work**?

2. ☐ **This worker can resume Regular duties. Start date** dd mm yyyy

☐ **This worker can begin Modified duties. Start date** dd mm yyyy

☐ **This worker is not able to work because of the workplace injury/illness.**

Please provide explanation

What **functional abilities** do you indicate?

3. Please indicate the worker's status and functional abilities in relation to the workplace injury and diagnosis.

A. Full Functional Abilities ☐

B. Worker Functional Abilities

	Able to	Not Able to		Able to	Not Able to		Able to	Not Able to
Bend/Twist	☐	☐	Operate Heavy Equipment	☐	☐	Stand	☐	☐
Climb	☐	☐	Operate a Motor Vehicle	☐	☐	Use of Public Transportation	☐	☐
Kneel	☐	☐	Push/Pull	☐	☐	Use of Upper Extremities	☐	☐
Lift	☐	☐	Sit	☐	☐	Walk	☐	☐

C. Other Limitations: eg. Environmental Conditions, Medication, Use of Protective Equipment.

Please describe: _____

Incident

F. Return To Work Information - Must be completed by a Health Professional

When work injury/illness occurs, focus on return to usual activity including return to safe and appropriate work is best practice. Most workers who experience soft tissue injury are able to remain at work.

1. Have you discussed return to work with your patient? ☑ yes ☐ no

2. ☐ **This worker can resume Regular duties. Start date** dd mm yyyy **If graduated hours required please specify**

☑ **This worker can begin Modified duties. Start date** dd mm yyyy Today **If graduated hours required please specify**

☐ **This worker is not able to work because of the workplace injury/illness.**

Please provide explanation **Able to work modified duties. Avoid heavy (> 5 lbs) and/or repetitive lifting, twisting and overhead work.**

3. Please indicate the worker's status and functional abilities in relation to the workplace injury and diagnosis.

A. Full Functional Abilities ☐

B. Worker Functional Abilities

	Able to	Not Able to
Bend/Twist	☐	☑
Climb	☐	☑
Kneel	☐	☑
Lift	☐	☑
Operate Heavy Equipment	☐	☑
Operate a Motor Vehicle	☑	☐
Push/Pull	☐	☑
Sit	☑	☐
Stand	☑	☐
Use of Public Transportation	☑	☐
Use of Upper Extremities	☑	☐
Walk	☑	☐

C. Other Limitations: eg. Environmental Conditions, Medication, Use of Protective Equipment.

Avoid prolonged sitting and prolonged standing (< 20 min) and repetitive and/or heavy lifting (< 5lbs), twisting and overhead work. Also avoid ladders and working at heights. Allow for frequent position changes. Follow-up in 2 weeks.

1. Disability is biopsychosocial – it is not explained by medical factors alone.
2. Prescribe staying at / early return to work that is SAFE and SUITABLE as part of your treatment plan.
3. Prescribe restrictions (safety) and limitations (capacity) to ensure success for your patient.
4. The conversations we have with patients about work have a major impact on successful return to work.
5. Use forms to operationalize care, not just document it.

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Questions and Discussion

Resources

Tools

Links to resources shared today will be sent to participants following the session.

Tools and Resources

Resource Type	
Guidelines	ACOEM – Preventing Needless Work Disability by Helping People Stay Employed Waddell & Burton – *Is Work Good for Your Health and Well-being?*
Patient Resources	WSIB Return-to-Work Information for Workers Return to Work: Information for Workers | WorkSafeBC (WorkSafeBC video but still applicable)
Practice Resources	WSIB Physician Learning Modules (Mainpro+) WSIB Forms & Physician Resource Hub
Education	CFPC Occupational Medicine Clinical Snippets eBook

Resources

Education

Links to resources shared today will be sent to participants following the session.

Upcoming Community of Practice Events

Holding Risk with Care: Form 1 Decision-Making in Family Medicine

May 27, 2026
8:00am – 9:00am

Register Now

REGISTER TODAY!

Ontario College of Family Physicians

Health Equity Community of Practice for Family Physicians

April 30, 2026 | 12 P.M. - 1 P.M. EST

Caring for Adults with Intellectual and Developmental Disabilities

Click here or scan the QR code

Upcoming Changing the Way We Work Community of Practice

Infectious Disease & New Guidelines on Endometriosis
with Drs. Daniel Warshafsky & Olga Bougie

May 1, 2026
8:00am – 9:00am

Register Now

The Changing the Way We Work Community of Practice for Ontario Family Physicians is a one-credit-per-hour Group Learning program that has been certified for up to a total of 32 credits.

Mentorship Program - Connect with a Peer Guide!

Interested in continuing your learning journey while prioritizing your own well-being?

Connect with another family physician through OCFP's one-to-one mentorship program for educational support on topics related to physician wellness, mental health, chronic pain and substance use disorders.

Examples of topics Peer Learners have explored:

- Guidance for setting boundaries/work-life balance
- Managing chronic pain and long-term use of opioids

Scan the QR code for more information!

Peer Connect

practisingwell@ocfp.on.ca