SIRA Health Outcomes Framework for the NSW Workers Compensation and Motor Accident Injury/Compulsory Third Party Schemes: Consultation Paper

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Consultation Questions

1. How can the health outcomes framework be most effectively used to improve health outcomes and the value of healthcare expenditure?

In general, the SIRA Health Outcomes Framework for the NSW Workers Compensation (WC) and Motor Accident Injury/Compulsory Third Party (CTP) Schemes (the Framework) can be most effectively used as a reference to guide activity and discussion with stakeholders. It points to key areas for action where the journey of an injured person through the system can be explored and enhanced to ensure that health outcomes can be optimised, and healthcare delivered efficiently.

The World Economic Forum [1] notes that 30-50% of the USD 6.5 trillion spent worldwide on healthcare is wasted. In Australia, an ABC Four Corners report [2] in September 2015 revealed that health expenditure is estimated at around $155 billion per year, and that about 30% of that expenditure, i.e. $46 billion is ineffective, and potentially unsafe. By reducing waste in the system, funds can be reallocated to interventions that deliver value by improving patient outcomes. The World Economic Forum describes value-based healthcare, as being built on the premise of aligning all stakeholders of a system towards value delivered to patients [1].

Therefore, the Framework can be most effectively used by implementing a process to identify where waste exists in the system, facilitate the evolution towards delivering services of high value, and eliminate services of low value for injured persons.

There are some areas of the Framework that require clarification and need to be outlined to fully determine how the health outcomes framework can most effectively be used.

Firstly, outcome (sub domain) 2.2 uses the same wording as 4.2, i.e. *'Cost of healthcare service is aligned with market rates for industry peers*.' This appears to be an error as the wording used for 2.2 is incongruent with the corresponding Domain of Injured person experience and accessibility.

Recommendation 1: ESSA recommends that elements of the Quadruple Aim are linked with Domains and Outcomes (sub-domains) within The Framework.

The Framework and the NSW Ministry of Health identify the Quadruple Aim with four essential elements for delivering value-based healthcare. It is unclear how the essential elements connect with domains and outcomes (sub-domains) within the Framework and this is left to the reader to make assumptions. It would be beneficial to provide clarification on how the Quadruple Aim aligns with the Framework for those without prior knowledge of the Quadruple Aim and how it is intended to be used within the healthcare system.

To address the questions posed by the Quadruple Aim, with all elements working towards integrated team-based care, the following needs to be explored:

- how injured persons will be initiated into the scheme based using a person-centred approach
- how injured persons will be referred from one provider to the next
- how providers effectively communicate with each other to provide value based and integrated care that adds to the patient and provider experiences
- how pathways will seek to reduce costs.

Recommendation 2: ESSA recommends that equal weighting be given across the essential elements of the Quadruple Aim.

The Concepts of the Quadruple Aim outline the areas for improvement, however there is no clarity provided on the metrics to assess and determine progress in each of these essential elements. The first two elements of the Quadruple Aim are related to the injured person, 1. *'health outcomes that matter to patients'* and 2. *'experiences of receiving care'*. The NSW Ministry of Health have developed a Patient Reported Measures Framework [3] to drive work in this area. It is not clear from The Framework presented by SIRA whether Patient Reported Outcome Measures and Patient Report Experience Measures will be utilised in The Framework.

It is not possible to determine from The Framework encompassing the Quadruple Aim, how metrics that incorporate outcomes, patient satisfaction/experience and cost are going to be considered. For a sustainable system, these measures are equally important.

Recommendation 3: ESSA recommends a person-centred care approach be implemented within the Framework (Domain 1, 2, 3, 5).

It is unclear from the Framework if the focus is on a patient-centred care or a person-centred care approach. The two concepts have similarities but differ in relation to goals and care delivered. Patient-centred care focuses on a functional life for the patient, whilst person-centred care focuses on a meaningful life where the whole life of the patient is considered [4]. Clarification in the

Framework would assist providers to deliver on the relevant aspects of care. ESSA acknowledges that this would be a change to how the scheme has previously provided care for injured persons.

In June 2020, SIRA launched a strategic framework for guiding work impacting mental health, titled Engaging with Lived Experience [5]. This framework calls for the voice of lived experience to be embedded in design, delivery, and improvement. There is no mention of the adoption of the Engaging with Lived Experience framework which focuses on better outcomes and greater impact through a patient-centred approach. This could be a useful resource to support work in the WC and CTP schemes.

Box 1: Case studies from injured persons treated in the NSW Workers Compensation Scheme

Case study 1: Mary (not her real name) had been receiving treatment from an accredited exercise physiologist for several months when a review of her treatment was requested. On review from an Independent Physiotherapy Consultant (IPC), the holistic treatment of Mary was deemed unnecessary. She has comorbidities with obesity and poly cystic ovary syndrome which was significantly impacting on recovery from a work-related lumbar spine injury.

The AEP was advised that treatment for comorbidities was not relevant in this case.

Case study 2: When Dan (not his real name) had been receiving treatment from an accredited exercise physiologist for numerous months, a review was requested. On review from an IPC, holistic treatment for Dan was deemed unnecessary. He was suffering from Post-Traumatic Stress Disorder (PTSD) and also presented with moderate-severe patellofemoral osteo arthritis with a complex tear of his meniscus; the latter was affecting his recovery from PTSD due to difficulty in achieving a level of intensity of exercise in order to address exercise stimulated release of monoamine neurotransmitters. The IPC advised that treatment for comorbidities was not relevant in this case.

These cases demonstrate a lack of a person-centred care approach. The Principles of Practice for Workplace Rehabilitation Providers published in September 2019 by the Heads of workers' Compensation Authorities acknowledge that, *'Workplace Rehabilitation Providers may also be engaged to assist with non work-related goals for work readiness activities'* [6]. Exercise physiologists are included in the list of relevant professions to be recognised as Workplace Rehabilitation Providers.

Recommendation 4: ESSA recommends that AEPs be systematically engaged in sharing their experiences to ensure that benefits from the treatment they provide can be realised (Domain 6).

This recommendation speaks directly to the third element of the Quadruple Aim which focuses on *'improving experiences of providing care'*. To this end, The Framework lacks information on how providers are to be engaged in sharing their experiences.

Exercise physiology is not well understood by insurers and claims agents as well as other well established healthcare providers. Active therapy delivered by exercise physiologists is rarely considered at the time of initial injury assessment. ESSA members report that the average time to referral to an exercise physiologist is currently 37-38 weeks. This delay has a

significant impact on the injured person as they present to exercise physiologists following a long absence from the workplace. This delay can cause psychological affects in addition to the physical deconditioning from a lack of structured exercise to improve functional capacity.

The research paper, Realising the health benefits of good work [7] highlights that being off work for long periods of time can significantly reduce the likelihood of a worker ever returning to work and can have a negative effect on the worker and their family. The paper indicates work plays an important role in any rehabilitation process because 'doing' promotes recovery. If a person is off work for:

- 20 days, the chance of ever getting back to work is 70 per cent
- 45 days, the chance of ever getting back to work is 50 per cent
- 70 days, the chance of ever getting back to work is 35 per cent.

Exercise physiologists need to be involved in the treatment of injured persons early in the return to work journey, collaborating with other healthcare providers to optimise the transition from acute treatment to sub-acute treatment in an effort to avoid an injured person's condition becoming chronic.

Recommendation 5: ESSA recommends that effectiveness and efficiency of care include measures for the performance of insurers and claims agents (Domain 1, 2, 3, 4).

The final element of the Quadruple Aim focuses on *'improving effectiveness and efficiency of care'*. Care is delivered by the entire system and therefore metrics need to be developed to assess the cost of insurers and claim agents processes in addition to healthcare services delivered by providers. The Framework does not provide clarity on measures that focus on the performance of insurers and claims agents and how this can contribute to health outcomes and the value of healthcare expenditure.

Box 2: Case study from injured persons treated in the NSW Workers Compensation Scheme

Ben (not his real name) [redacted] *sustained an injury to his lower back resulting in disc bulges between vertebrae L2-S1 with disc herniation at L4/5 and L5/S1. Thecal sac indentation from L3-S1 was also evident and required surgery in October 2019. Following the surgery, Ben received treatment from a physiotherapist and osteopath once to twice weekly, but there were few gains with persistent pain and poor mobility. Ben commented on the treatment as being a 'band-aid'.*

In February 2020, Ben was referred for treatment with an exercise physiologist, and a prescription of three sessions per week was recommended and subsequently approved by the case manager. After two applications through the Allied Health Recovery Request (AHRR) process and 16 consultations, significant improvements in all areas of functional capacity were achieved including improvements in perceived pain, improved self-efficacy and mental health (increased willingness to return to work), increased lower limb and core strength (high levels of lifting from the floor and overhead in occupation), flexibility/mobility and ability to manage pre-injury duties with minimal discomfort. He also scored improvements on psychometric tests and was cleared for pre-injury duties.

Sadly, the timing of this progress coincided with the commencement of restrictions due to the COVID-19 pandemic and Ben lost contracts for his business. The loss of his contracts had a detrimental impact on Ben, leading to depression and failure to attend treatment sessions. After 3 weeks, he agreed to return for treatment, but the new case manager was not prepared to approve the previous exercise prescription despite its demonstrated effectiveness. The case manager approved a decrease to the treatment dose by 30%, with no rationale provided for the reduction. The exercise physiologist spent considerable time negotiating with the insurer for previous evidence-based treatment to be provided for Ben.

Eventually this was granted and after three further AHRRs of 24 consultations, he was recommended for pre-injury duties with no restrictions. This was a long journey for Ben, and he is now ready to return to work.

In summary, this case demonstrates clear barriers in the system for injured persons to access cost effective, evidence-based treatment in a timely manner. The first unnecessary cost is associated with the prolonged delivery of physiotherapy and osteopathy despite limited gains. A timelier referral to exercise physiology services would be more cost effective. A lack of knowledge by the new case manager led to inappropriate approvals of a lower treatment dose via the Allied Health Recovery Request (AHRR) process and additional negotiations to ensure evidence-based treatment was delivered. In this case the rationale provided in the AHRR was not respected by the new case manager. The resultant impact on the healthcare provider was one of disempowerment and feelings of disrespect for their professional standing. The fragmentation in care was also demotivating for the injured person. The requirements for five AHRRs for exercise physiology services in this case also demonstrates a significant cost to the system in reporting and application requirements.

The current (AHRR) process creates significant delays and acts as a barrier to treatment for injured people in a timely manner. The time required for processing is consistently too long and the approval of eight sessions of exercise physiology for injured people with chronic and complex conditions is insufficient. Continuity of care is affected by these delays and the fragmentation results in a loss in the gains from treatment delivered.

Recommendation 6: ESSA recommends that qualitative measures be considered to evaluate the impact of the essential elements of the Quadruple Aim.

Quantitative data is the only measure for success outlined in The Framework. There does not appear to be qualitative measures being considered in The Framework and the first three essential elements of Quadruple Aim should involve the collection and analysis of qualitative data to explore:

- Health outcomes that matter to patients
- Experiences of receiving care
- Experiences of providing care

The health outcomes framework can most effectively be used to improve health outcomes and the value of healthcare expenditure if qualitative measures to assess the essential elements of the Quadruple Aim could be collected and analysed in addition to the quantitative measures proposed.

2. (For scheme participants) Is the outcomes framework useful to you/your organisation in clarifying the vision and direction for healthcare in the WC and CTP schemes?

Yes, it is helpful to know that the vision and direction of The Framework is focused on delivering a sustainable WC and CTP scheme in NSW. ESSA is optimistic that The Framework will deliver on the promises outlined in the 6 domains with application universally applied across the health care disciplines within the scheme. These domains are broad and focus on providers delivering services that are evidence-based and present value for the injured person and the system. These are two principles that AEPs consistently apply to their service delivery.

Recommendation 7: ESSA recommends that a definition for value-based care be stated in the Framework.

The consultation paper advises that The Framework is consistent with NSW Ministry of Health definition of value-based healthcare. The Framework has not stated that it is adopting the NSW Ministry of Health definition and therefore, this infers that there are some similarities but also some differences. The NSW Ministry of Health Vision of Value based healthcare in NSW is for, '*A sustainable health system that delivers outcomes that matter to patients and the community, is personalised, invests in wellness and is digitally enabled.'*

The Australian Centre for Value-Based Health Care [8] describe a value-based care approach as collaborative, driven by patients, clinicians and the community. The aim of this approach is to deliver the best outcome for the patient and the best value for the system. They point to a definition provided by the World Economic Forum which describes value-based healthcare as:

> '*The health outcomes that matter to patients relative to the resources or costs required.'*

3. (For scheme participants) Will the outcomes framework influence your approach to healthcare in WC and/or CTP? And if so, when and how?

The overwhelming response from AEPs working in the Workers Compensation Scheme in NSW, is that the outcomes framework would not influence their approach to healthcare. If metrics are collected that focus on health outcomes, patient experiences and patient reported outcomes, then the Framework will validate the services provided by AEPs. This will set a standard for the delivery of quality of services and identify high performing providers.

AEPs are recognised allied health professionals (AHPs) who provide clinical exercise interventions aimed at primary and secondary prevention; managing acute, sub-acute and chronic disease or injury; and assist in restoring optimal physical function, health, and wellness. Exercise physiology is a recognised and funded profession under compensable such as Medicare Benefit Services (MBS), Department of Veteran Affairs (DVA), the National Disability Insurance Scheme (NDIS), and private health.

AEPs take a person-centred approach in the provision of services and ESSA's scope of practice [9] describes activities including:

- Screening, assessing and applying clinical reasoning to ensure the safety and appropriateness of exercise and physical activity interventions, which includes conducting tests of physiological measures.
- Assessing movement capacity in people of all ages and levels of health, well-being or fitness.
- Development of safe, effective individualised exercise interventions.
- Provision of health education, advice and support to enhance health and well-being including nutritional advice in line with national nutrition guidelines and information on relevant prescribed medicines.
- Provision of exercise intervention and education for those at risk of developing a chronic condition or injury.
- Provision of clinical exercise prescription, for those with existing chronic and complex medical conditions and injuries.
- Provision of exercise-based rehabilitation and advice for patients in the acute/sub-acute stage of injury, surgical intervention, or during recovery to restore functional capacity and well-being.
- The above tasks may occur at any level of primary, secondary or tertiary health care, and may include employment or volunteer work at an individual, community or population health level through various employers or industries.

The implementation of this scope of practice and adherence to the Clinical Framework for the Delivery of Health Services [10] positions AEPs to continue to deliver on the six Domains identified in the Framework. Thus, contributing to the Quadruple Aim and ultimately to improving health outcomes and utilisation of healthcare expenditure.

Exercise physiologists provide a structured and supervised program to build the skills and self-efficacy of the injured person to ultimately self-manage. Non-adherence to home based, self-managed physical rehabilitation therapies can be as high as 70% [11], therefore injured people are not realising the benefit of treatment in these circumstances.

Box 3: Case study showing outcomes from an exercise physiology business

For the Financial year 2019/2020, data from approximately 2000 injured people treated by an exercise physiologist in the NSW Workers Compensation Scheme was analysed.

Outcomes showed:

- *Average program duration – 18 weeks*
- *Average supervised reviews – 9 sessions*
- *Average change in work hours – improvement of 19 hours (initial work hours) to 27 hours (final work hours)*
- *Final Work Capacity – Final certificate (33%), Increased capacity (21%), Full capacity for work (19%), Some capacity for work (9%)*
- *Clinically significant changes – 81% improvement using validated screening tools for assessment*

Feedback expressed:

- *How do you rate the overall service provided during your exercise program? 92% Excellent, 7% Good, 1% Average*
- *Do you think your exercise program has assisted you in bettering your health to help you in completing your normal daily routine and activities outside of work? 97% Yes, 3% No*
- *Do you think your exercise program has assisted you in bettering your health to help you in participating in your hobbies, recreational and social activities? 91% Yes, 9% No*
- *Do you think your exercise program has assisted you in bettering your health to help you in returning to work? 85% Yes, 15% No*
- *How confident are you that you now have the tools to continue with an exercise program independently in the long term? 43% Extremely Confident, 42% Very Confident, 15% Somewhat Confident*

Comments shared:

"I truly believe that [redacted] was instrumental in my recovery and return to work. I believe that without her my recovery would not have been so swift. [redacted] displayed professionalism, empathy and commitment to my overall recovery. [redacted] also taught me not only to keep my body and mind healthy but to move forward and attain my goals."

"With my injury [redacted] accommodated my needs if and when I had a flare up due to me over doing things. [redacted] also allowed me to contact him out of business hours to discuss any issues I was having and for any advice on the program he had given me. His knowledge of my injury was a big part of how well I am doing now, providing a program that suited my type of injury. Not only was he able to help me physically with my injury, but he also helped me mentally as I had been very frustrated and started to fall into a depressed state, due to the length of time I had not been able to perform my work and daily activities. He gave me guidance, advice and reassurance, plus kept me thinking positive that he would get me back to performing my daily activities and jobs at work that I could do before my injury and operation."

"[redacted] really helped me get back to work and strengthen my knee. Also has given me the education on how to make this a lifestyle change as it likely an injury that will recur in my line of work. Always turned up and on time, always available and helpful."

"[redacted] managed to bring me out of my rehabilitation slump and not only educate me in what exercises worked for my injury at the present and for in the future, but his attention to detail and work ethic also helped me mentally, making me want to push myself for me and not because I was required to by my employer. He made it known from the first session that he was available via email at any time if I had any concerns. For me, knowing that I had that full support from my EP no matter what the issue was really helped me push the boundaries mentally and helped foster my drive to exercise/bring back my motivation which I had lost. I owe [redacted] everything for where I am today in my rehab. I began the program lost, lacking confidence and feeling helpless in my abilities. I've finished the program with a solid education in exercises and rehabilitation, stronger (mentally and physically) and feeling confident in myself (which has been severely lacking for the past year). I know I have a better opportunity of returning to full duties now because of this program."

4. What can WC and CTP scheme participants (insurers, health practitioners, claimants, employers) do to help advance the vision of value-based care in the schemes?

Providers of healthcare within the scheme have insight into the journey of the patient through the system, including knowledge of enablers and barriers. These relate directly to the domains outlined in The Framework and exercise physiologist are willing to share their knowledge and experience, working collaboratively with SIRA towards realising the vision of The Framework.

On consultation with ESSA members, the following was expressed as to how exercise physiologists could be actively engaged and work collaboratively to support the vision of The Framework:

'Willingness to collect qualitative and quantitative data across all domains, providing infrastructure as an enabler for data capture'.
'Deploy communication system to enhance engagement with other healthcare providers.'
'Provide stories of positive experiences and challenges in the system to assist in improvements in the delivery of and quality of care.'
'Present innovative solutions incorporating inter-disciplinary care and psychosocial factors particularly for chronic patients.'

Recommendation 8: ESSA recommends that claims managers employed by insurers and other healthcare providers within the scheme including GPs, physiotherapists and other allied health undertake training to better understand the role of exercise physiologists to ensure that benefits of active therapy can be realised by injured persons (Domain 1, 2, 3, 6).

ESSA can help advance the vision by providing training to support staff employed by insurers and other healthcare providers in the scheme. ESSA manages the Australian delivery of Exercise is Medicine® (EIM) [12] a global initiative lead by the American College of Sports Medicine (ACSM) [13]. Training through EIM has been developed for General Practitioners (GPs), Primary Care Nurses and Allied Health Professionals to highlight the role of multidisciplinary care and AEPs in assisting patients to establish an exercise program best suited to their needs. This encompasses the importance of exercise for overall health and introduces subsequent behaviour-change strategies specific to the adoption of exercise as a regular part of a patient's lifestyle. The training carries continuing professional development points for General Practitioners and Primary Care Nurses.

The role of AEPs is not well understood and this is evidenced through late referrals to an AEP for active treatment. There is evidence to show that there are key barriers to GPs prescribing exercise for patients including knowledge, confidence, and a lack of training [14] [15]. This indicates a gap in education.

Box 4: Example responses from participants in EIM

What did you find the most interesting/relevant?

- *Information on what an Exercise Physiologist does and when to refer*
- *Difference between a Physiotherapist, Exercise Physiologist and Personal Trainer*
- *Role of exercise in health promotion and disease management*

How might this activity contribute to a systems-based patient safety outcome for your practice?

- *Helps to promote health and wellbeing for the patient. Working with AEPs ensures exercise program is safe and effective for patient goals.*
- *I can encourage our Clinic Doctors to refer more patients to Exercise Physiologists to encourage the patients to be more active.*
- *I think it provides clear guidelines for practitioners and encourages them to take an extended (non-medical but holistic) approach in a patients treatment plan and if referrals are monitored and evaluated properly the prescribed exercise plan is a powerful tool to enhance a patient's health.*
- *Ability to identify clients' needs and which professional to refer them to.*

Whilst this is a general education program, ESSA is willing to explore the development of a version specifically focused on the WC and CTP sector and made available for all stakeholders. This will focus on the inter disciplinary team approach to transitioning the injured person from acute to sub-acute and then returning to pre-injury duties. Common injuries could be explored as part of this education and best practice pathways discussed. There are efficiencies that can be made by the utilisation of exercise physiology at the right time in the return to work journey for the injured person.

This action will enhance the knowledge and capability of healthcare providers (6.3) in the system to focus on outcomes for the injured person, engaging them in active treatment from an exercise physiologist at the right time in the return to work journey.

Box 5: Case study from injured persons treated in the NSW Workers Compensation Scheme

Harry (not his real name) works as a [redacted] full time where he constantly lifts beams of 25-30kg and carries them up and down stairs and ladders. During this activity he is reaching, twisting his upper body, and standing for prolonged periods of time. He also engages in a lot of heavy pushing and pulling of equipment and trolleys. At the age of [redacted], the impact of his work led to disc desiccation and a marked loss of disc height at L5/S1.

On assessment his lumbar range was 50% of the potential range and squat range 75%, pain was up to 9/10 on the Visual Analog Scale (VAS) for pain and he was unable to lift and carry more than 12.5kg. From a personal perspective the pain impacted on his ability to care for his children and engage with them in a game soccer. The neurosurgeon advised Harry that there was little chance that he would return to pre-injury duties as a scaffolder and potential for surgery if conservative treatment did not improve his condition.

Treatment immediately post injury was 14 weeks of physiotherapy including passive therapies and some floor-based exercises. At 16 weeks, he was referred to an exercise physiologist for active treatment with a strength and conditioning program. This lasted for 3 months and Harry returned to full pre-injury duties two weeks before the end of the program.

He now has full lumbar and squat range, pain at its worst is 7/10 on the VAS scale and can lift 37.5kg from the ground. He is thrilled to now be able to kick the ball and play with his children.

From a process perspective the following codes were utilised - EPA001 Assessment, EPA002- Standard Consult x 12, EPA006- Medical Case Conferencing to liaise with the Nominating Treating Doctor (NTD) and Occupational Rehabilitation provider on multiple occasions to update them on his progress and improvements to his capacity, EPA007- 1 x Progress Report and Final Report to engage the Neurosurgeon, NTD and Vocational Rehabilitation provider with structured updates on his capacity and timeframes for return to Pre-Injury Duties and OTT007- Three Month Gym Facility Fee to replicate the heavier aspects of his pre-injury duties and allow Harry regular self-directed access to build his strength.

This case demonstrates collaboration between healthcare providers and cost savings to the scheme as surgery was avoided due to active treatment. The neurologist negotiated with the injured worker to consider alternative treatments to surgery and promoted a conservative approach. This allowed the injured person to undergo a structured exercise and strengthening program and facilitated a timely return to pre-injury duties. To achieve this the AEP utilised many service codes due to the engagement with the whole interdisciplinary team including physiotherapy, occupational therapy, NTD and neurosurgeon.

The World Health Organisation notes that developing a strong multidisciplinary rehabilitation workforce is supported through health workforce education.

Recommendation 9: ESSA recommends that pre-approval for treatment from an AEP be considered on initial assessment of an injured person (Domain 1, 2, 3, 5).

When an injured person is assessed the entire rehabilitation journey needs to be considered, incorporating a plan and an interdisciplinary team approach to be enacted. There is often a team of providers that are required to work collaboratively to address acute issues and transition the injured person to the exercise physiologist to build functional capacity to return to work. The requirement to return to a NTD for approval to receive treatment from an AEP creates delays, adds cost and fragments care for the injured person. The delays can be weeks and sometimes months.

Implementation of this recommendation will assist with 2.4 which states, *'Healthcare for injured persons is integrated across the continuum of need. Transitions between types of care/disciplines are effectively facilitated to enable continuity of care.'*

Recommendation 10: ESSA recommends that care coordinators and/or a triage service be considered to support injured workers with early access to healthcare and to navigate the system (Domain 1, 2, 3).

It is essential to have a streamlined communication process to help eliminate barriers in the system and facilitate the journey from injury back to work. This particularly the case for the management of psychological claims as outlined in Taking Action: A best practice framework for the management of psychological claims in the Australian workers compensation sector [16]

Engagement of skilled and knowledgeable staff by insurers and claims agents will assist to enhance the injured persons experience and accessibility.

Box 6: Case study of a triage service in a Workers Compensation Scheme

Injurynet Australia have a triage service supported by registered nurses with knowledge in injury and can channel injured workers towards the most appropriate level of care. They coordinate appointments with doctors or allied health professionals and facilitate early access to healthcare in a timely manner.

Currently the claims managers in NSWs have variable knowledge and there are inconsistencies in what is approved for treatment. Some of the claims managers have the knowledge and skills to facilitate appropriate care for injured persons but others create barriers and delays in the system.

Box 7: Case study from injured persons treated in the NSW Workers Compensation Scheme

Jack (not his real name), aged [redacted] is employed full time as a [redacted]. He injured his knee at work during an incident which combined squatting and twisting, resulting in pain where he was unable to work for three days. His GP arranged imaging and referred him for treatment with an exercise physiologist whilst his claim was being assessed. Three weeks of active therapy was delivered combined with education where Jack successfully implemented self-management strategies. He had a good response to initial stages of treatment and was making steady progress when the claim was denied by the insurer. The rationale provided for cessation was that this was deemed to be a pre-existing condition. There had been extended deliberation over the imaging which showed degenerative changes in the knee joint. There was a clear mechanism of injury and despite progress with treatment and evidence suggesting that degenerative changes may not necessarily be reasoned as a primary cause of pain, treatment was ceased.

In this case the claims agent chose to ignore the evidence that the work incident led to the pain experienced by the injured worker, subsequent absence from work and need for treatment. The claims manager lacked the skills and knowledge to make an appropriate decision in this instance. The evidence, i.e. imaging presented did not confirm that degenerative changes were the cause of the pain. The outcome was that treatment that was building Jack's functional capacity to return him to pre-injury duties was ceased.

Other similar scenarios to the case study, where pre-existing conditions are present but not the cause of the pain have been approved for continued treatment. This demonstrates that there are inconsistencies in the system.

Recommendation 11: ESSA recommends that the Framework's vision, aims, domains and outcomes be communicated with all stakeholders utilising a variety of media (Domain 6).

To build engagement with all stakeholders, effective communications would assist to increase knowledge, understanding and collaboration in the implementation of The Framework. Assets will need to be developed to convey a clear purpose of the and a variety of communication channel utilised in delivery.

ESSA can assist by facilitating communicating with AEPs in NSW on The Framework. This can include learning opportunities through the continuing professional development program.

Recommendation 12: ESSA recommends that barriers are removed for AEPs to support injured persons to utilise community facilities such as gyms and swimming pools (Domain 1, 2, 3).

SIRA does not generally support membership of gyms and swimming pools for the injured workers to utilise in their rehabilitation and requests by AEPs is usually denied. Socialising injured workers to exercise and engage in utilisation of these community facilities supports transition back to work and integration with the community.

AEPs build self-efficacy and self-management skills in injured persons and increasing choices to utilise community facilities in treatment assists in adherence and results in a longer-term impact. Barriers exist to injured persons fully participating in treatment and increasing access and providing flexibility will further support return to work rates.

This action works towards addressing factors affecting the welling of the injured person, i.e. domain 3. *Connecting injured persons with community-based facilities* is particularly relevant for those that are in the chronic stage of injury where there is a higher risk of social isolation and reduced community engagement. Providing AEPs with the opportunity to support injured persons to exercise in these settings facilitates social engagement, feelings of connectedness and builds resilience. This active engagement helps to empower the injured person to return to work.

Recommendation 13: ESSA recommends that a system of peer review needs to be established for exercise physiology which includes the engagement of Independent Exercise Physiology Consultants (Domain 5, 6).

Currently there is no process for peer review for exercise physiologists in the system. SIRA have advised that the use of Independent Physiotherapist Consultants (IPCs) is the process for reviewing the work of exercise physiologists.

It is not appropriate for physiotherapists, nor any other health professional that has not completed the recognised exercise physiology qualifications and/or practised as an AEP, to provide peer review to exercise physiologists. AEPs and physiotherapists have different scopes of practice and are subject to different regulatory requirements. The Principles of Practice for Workplace Rehabilitation Providers published in September 2019 by the Heads of workers' Compensation Authorities acknowledge that physiotherapy and exercise physiology are separate professions and are included in the list of relevant professions to be recognised as Workplace Rehabilitation Providers [6].

The current system creates an adversarial environment where one profession is standing in judgement over another profession. This engenders an atmosphere of suspicion and disrespect between professional groups who should be working in collaboration for the benefit of the injured person.

Box 8: Case study from injured persons treated in the NSW Workers Compensation Scheme

Monica (not her real name) worked as [redacted] *and strained her lower back while handling a patient. For the first 12 months post injury she received physiotherapy, then micro-discectomy surgery followed by more physiotherapy. The number of sessions of physiotherapy is unknown but had failed to sufficiently improve her functional capacity.*

Following a period where there was no treatment, Monica was referred for exercise physiology. At this point she was deconditioned and had been in the system for over 4 years. Over the next 12 months she received 88 sessions of exercise physiology. Monica faced multiple barriers with ongoing pain and absences due to treatment with intra-articular facet joint corticosteroid injections, illness, family commitments and weight management difficulties. Whilst there was some improvement the lack of inconsistency of treatment had not resulted in gains over the last 3 months and an IPC was engaged to conduct a review.

The recommendation from the assessment was that remaining sessions be used to consolidate self-management strategies and encourage Monica to engage in pre-injury recreational activities of visiting the gym for exercise. Upon return to work it was recommended that access to eight standard physiotherapy treatment sessions be made available.

Whilst there were elements of the review that were valid there were inaccurate and inappropriate statements expressed by the IPC about the knowledge, skills and expertise of exercise physiologists. Monica relayed comments from her interview with the IPC where he said, 'Exercise physiology is a waste of time and not a real profession. They cannot diagnose, could hurt a patient and wouldn't even be able to tell them what they have hurt. They couldn't fix the problem cause they just stand next to a treadmill and watch you, making adjustments to the treadmill like a personal trainer.'

This case demonstrates the need to work to improve the safety and quality of healthcare (Domain 5) but also support the injured worker and wellbeing of the provider of the service (Domain 6).

There are other regulatory systems in Australia that utilise AEPs to provide peer review and support quality healthcare such as Return to Work SA.

Box 9: Return to Work SA model of peer review for exercise physiology

Return to Work SA employ an AEP who is involved in a peer review program where metrics are used to identify outliers in service provision delivered by exercise physiologists. The AEP advisor meets with the provider to identify issues/barriers, trouble shoot and deliver strategies for quality improvement. The findings from this program are used to assist in building education for inclusion in university courses as well as instructing claims agents on the work of exercise physiologists.

The approach delivered in this model helps to improve the quality of healthcare delivered whilst preserving the wellbeing of the healthcare provider.

In developing this submission, eight AEPs were interviewed and each of them raised the lack of peer review and use of IPCs as an issue that needs to be addressed. It was noted that review from an IPC

resulted in cessation of exercise physiology services 100% of the time and was often combined with a recommendation for treatment from a physiotherapist.

Box 10: Case study from injured persons treated in the NSW Workers Compensation Scheme

Terry (not his real name), [redacted] *sustained a back and lower limb injury after falling from his vehicle. After receiving physiotherapy, treatment from an AEP was introduced to facilitate a transition in his return to pre-injury function. This was approved by the NTD, the treating physiotherapist and Terry. Over 6 sessions, he showed progress and his function was returning. During this time, a review was conducted by an IPC who determined that hand over to an AEP was inappropriate. The treating AEP was not consulted and whilst Terry had improved, the decision to cease treatment interrupted progress towards return to work. There was evidence to support continued treatment, but no evidence to support ceasing treatment. He continued physiotherapy for a period of greater than 12 weeks and was still unable to return to work.*

This case study demonstrates a barrier to effective interdisciplinary collaboration with the person at the centre of care. The outcome resulted in denial of access to effective care, being delivered in a timely manner. Potentially this also contributed to additional costs due to delays in accessing active treatment to build functional capacity and return to work.

5. **Are there areas where you believe SIRA should focus its implementation efforts to best promote achievement of value-based care?**

Yes, there are several areas where SIRA should focus implementation efforts to best promote achievement of value base care, these include:

- **Engagement of providers and key stakeholders** such as ESSA to advise on delivery of domains identified in the Framework particularly in relation to metrics to be collected.
- **Identification of metrics that address the Quadruple Aim** including qualitative measures in addition to quantitative measures, and aligning them with the Clinical Framework for the Delivery of Health Services [10]. Return to work requires the restoration of functional capacity from both a mental and physical perspective.
- **Identify waste in the system**, particularly in relation to how insurers and claims managers operate. There is a need to increase the knowledge, skills and understanding of insurers and claims managers to increase efficiencies and reduce delays in returning injured workers to pre-injury duties.

Recommendation 14: ESSA recommends that SIRA directly engage exercise physiologists in codesign of the system.

AEPs are professionals that are underutilised in the system as their role is not well understood and inter disciplinary engagement is dependent on the knowledge of individual claims managers and other healthcare providers which is often lacking and results in inconsistencies.

AEPs are available and willing to share their experiences as providers. They have insight and can advise on the potential to make improvements in health outcomes and healthcare expenditure

to support sustainability of the scheme. There are numerous areas where AEPs can contribute including:

- Governance - Acting as a member of a clinical panel
- Working Committee – Sharing expertise to advance program and project areas
- Review – feedback on areas under development such as development of metrics
- Research – contribute the design and pilot of innovative programs and projects
- Education of other Healthcare providers, insurers and claims agents

6. Do you have any comments on the implementation plan?

Recommendation 15: ESSA recommends that the travel allowance be reviewed to remunerate providers of healthcare for the actual travel costs (Domain 6).

The current fee schedule for travel is $0.68 per kilometre yet the Australian Tax Office requires payment of $0.72 per kilometre. When providers are required to travel to deliver services they are currently out of pocket for the provision of services in the WC and CTP Schemes in NSW.

This issue is compounded when travel time is also not considered with remuneration for the provider.

Recommendation 16: ESSA recommends that SIRA provide competitive remuneration to all allied health to retain quality providers (Domain 6).

The Framework highlights that the NSW WC and CTP schemes will work to attract and retain high quality healthcare providers. The remuneration currently available to exercise physiologists through SIRA will not assist this process. The remuneration for exercise physiologists in NSW is lower than other compensable schemes such as the National Disability Insurance Scheme. The price limit for exercise physiology under the NDIS is $166.99/hr, 10-20% higher than the SIRA rate. Quality providers may prioritise work in more profitable areas.

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