Submission into the SIRA Health Outcomes Framework for the NSW Workers Compensation and Compulsory 3rd Party Schemes

The NSW Council of the Australian Rehabilitation Providers Association (ARPA NSW) appreciates the opportunity to contribute to the Health Outcomes Framework for the NSW Workers Compensation and Motor Accident Injury/Compulsory Third Party Schemes.

ARPA promotes an injured person's ability to access medical and treatment services and promotes early and easy explanation of what services are available and how to access these. ARPA promotes wellbeing through proactive and easy to understand processes for treatment approvals to ensure the client is empowered. The concern is that a new and complicated framework may not provide this accessibility and may in fact lead to further delays in seeking treatment and their impacting health and return to work outcomes.

ARPA NSW believes that the development of a Health Outcomes Framework (HOF) is good to see from a philosophical and theoretical perspective, however we have a number of questions and concerns that are outlined below.

Summary of feedback on Framework

After careful review and consideration, ARPA NSW believes that the health outcomes framework (HOF) needs to:

- incorporate workplace rehabilitation providers (WRPs) as part of the framework, due to many of the reasons already stated in our earlier submission (see previous submission attached). ARPA believes that a framework around medical and treatment costs cannot, in and of itself, expect to produce outcomes or value-based healthcare without WRP support to guide, support and monitor it
- have a whole person focus (within reason)
- consider issues such as the regulation of providers, the impact of deeds/SLA's etc with insurers etc. as it is difficult to see how the HOF will work in the way that it is hoped, as there are multiple factors that may impact its success
- consider WRPs to be the allied health experts if this framework is to be accepted and integrated, as without the coordination and input from a WRP, we believe that the framework will not work as SIRA believes it will
- focus on early intervention and ARPA would like to see evidence of how the HOF supports an early intervention model
- ensure that only accredited and experienced staff are eligible to provide services and that non-accredited parties are removed from delivering accredited service in NSW
- ensure that oversight of providers is less prescriptive in nature and that less micromanagement is provided by scheme managers, with an assumption within the schemes that providers will deliver services that are fair and reasonable
- align (wherever possible) with the National Safety and Quality Health Service (NSQHS) Standards which have been developed by the Australian Commission on Safety and Quality in Health Care.

The HOF recommended fails to represent WRPs in the model and ARPA strongly disagrees with this approach (page 11 points 3.2, 3.3, 4.1, 4.3, 5.1, 5.2, 5.3 and 6.3). WRP's function includes:

a) Education
b) Facilitation of quality and outcome-based treatment
c) Collaboration between treating parties and GPs
d) Alignment of treatment gains to return to work and capacity or function for work
e) Promotion and facilitation of engagement in social and community activities to reduce the psychosocial risks of injury on recovery.

The HOF as it stands focuses on some of these tasks being facilitated by injured clients and their employers who don't have the health literacy required or training to manage this effectively.

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

   The health care ecosystem described presents an ideal scenario of healthcare service provision aligned to health outcomes. As the framework applies to participants in the schemes who '*commission or provide healthcare services i.e. insurers and their agents, employers, and health providers'* it is critical to understand the drivers behind each cohort in applying the framework.

   People with injuries need varying degrees of medical and treatment care. Some very little and others with more complex presentations, much more. Those same people with injuries who require more medical and treatment support, are those that have historically been referred to WRPs. Amongst other services, WRPs ensure medical assessment and treatment services are coordinated, goal driven, evidence-based and timely, therefore ensuring care and spend is effective. By working closely with employers, WRPs additionally ensure that workers with injuries return to work to duties that are safe, medically, psychologically and functionally appropriate, and that are ultimately sustainable for the long term.

   Our industry has historically noted the impact that the lack of medical literacy by case managers who are charged with approving services has on the delay in service provision and therefore outcomes. The success of this framework is highly dependent on consultation between the insurers and services providers in ensuring health outcome goals are clear and evidence based. Specifically, the understanding of Allied Health Recovery Requests (RHRR) plans, holding practitioners accountable to proposed goals and understanding barriers to achieving those goals. These are critical elements of the role of workplace rehabilitation consultants and should be featured in the framework.

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?**

   In some ways yes. The framework has merit in communicating the overarching indicators for best practice care and specifies the metrics to be used across the six domains noted. However, having return to work captured as an outcome within the wellbeing domain is limited.

In the implementation stage – specifically Stage 2 (Enhanced Healthcare Data), without the clear inclusion of WRPs as a service provider or being an extension of the scheme agent, should ARPA assume that it will contribute to the body of evidence for poor RTW / health outcomes? Due to the current performance criteria expected of WRPs, a wealth of evidence exists with the databases of rehabilitation providers which would provide qualitative information on those critical factors that explain why health / RTW outcomes are not achieved.

As previously communicated by ARPA, data inconsistency remains the most destructive aspect for information and understanding. Presently there is no clear indication on who is the authority in respect of data. We believe that for transparency and consistency, SIRA should hold accountability and authority for scheme data.

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

ARPA is hopeful that SIRA can mandate insurers to complete the screening and identification of workers and motorists with injuries who:

- have complex injury presentations
- are likely to have more than two weeks of incapacity or four weeks of partial capacity
- present with psychosocial risks.

These workers and motorists represent the highest risk of prolonged treatment and recovery. As such they should be routinely referred to experts (rehabilitation providers) whose role it is to coordinate, manage, support, orientate and activate medical, treatment and return to work. Noting that work is a key factor and indeed a treatment modality considered of key importance in ensuring recovery and restoration of independence, this component of intervention is critical to recovery, health outcomes and cost effectiveness.

ARPA believes it critical that there is a clear, evidence-based, best practice approach to early intervention for new claims and that there is proactive and early engagement of workplace rehabilitation to facilitate early and sustainable return to work. As previously outlined, to facilitate the early engagement of workplace rehabilitation icare should:

1. Allow an automatic approval and funding for employer or treating doctor directed rehabilitation referrals in recognition of the employer's commitment to facilitating recovery at work.
2. Mandate early referral for workplace rehabilitation at 2 weeks (where the worker is likely to be off work for greater than 4 weeks).
3. Direct scheme insurers and agents to immediately approve referrals from employers, workers or treating doctors.
4. Ensure that training manuals, information and support available to agents and their team of case managers accurately represents early intervention and the benefits of same.
5. Train case managers on the effective use of workplace rehabilitation services, in particular on the benefits of early referral to workplace rehabilitation.

ARPA holds a critical position in the industry as allied health practitioners and occupational rehabilitation experts amongst the key participants including the person injured, their employer, treating allied health practitioners and scheme agents. Therefore, ARPA has an important role to play in partnering with SIRA and icare as a training partner in adoption of the framework by scheme agents.

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?**

   A key component in achieving health outcomes is excellence in communication. A key frustration observed across our industry is the lack of communication by scheme agents in the WC scheme. The delays in approval of treatment have impacts on the individual as well as the employer and in many instances cause an increase in psychological distress in dealing with a compensation claim.

   As clinicians working within the scheme it is critical that those decisions around approval for treatment particularly in the subacute and chronic stages are made by suitably qualified injury management specialists and not claims managers. Historically there has been poor and delayed decision making by case managers who adopt a one size fits all approach to specific conditions with little to no understanding of co-morbidities that may exist that could impact recovery. While the details required in the AHRR plan provides a good tool for communication, the recipient of that is the case manager who is not required to possess the medical literacy to understand the information or barriers that might be communicated. This argument reinforces the need for early referral to OR providers who have both the clinical and OR experience to manage health outcomes within the scheme.

   A further consideration is adequate remuneration for allied health providers (AHP) in completing such detailed AHRR plans. It has been the observation of ARPA that hasty non-specific plans are often completed due to the time constraints in preparing the AHRR plan. In addition, education needs to be provided to all AHP regarding the ability to charge for their valuable time in speaking with insurers, employers or WRPs and to understand the value this has in the overall goal of achieving best patient outcomes. Clinicians are running busy private practices and often do not understand their ability to charge for their time and thereby avoid doing so altogether.

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

   ARPA would like to see specific inclusion of the WRP industry as a key stakeholder – as a separate entity to the scheme agent to ensure the value and return on investment in rehabilitation in achieving health outcomes. ARPA appreciates SIRAs challenge of managing costs of healthcare vs outcomes and present the following factors previously communicated by ARPA that must be acknowledged to ensure success of this framework.

The specific factors impacting reasons for increase in service utilisation and medical cost include:

- an injury management system that does not effectively triage / screen people with injuries and their psychosocial risk profile
- nominal insurer instructions and training to agent case managers that contradict science and evidence-based best practice for injury management
- insurer / agent representatives and case managers that lack the education, training and skills to hold treatment and medical providers accountable to outcomes
- insurer / agent representatives and case managers that lack knowledge on evidence-based interventions to support recovery from the broad spectrum of injuries they are overseeing
- insurer / agent representatives and case managers that cannot either comprehend or apply the critical psychosocial approaches to mitigate longer term disability and therefore use of treatment and medical services
- a lack of people accountable for establishing SMART goals and gaining the endorsement of people with injuries, treatment and medical providers to ensure progress and achievement of these goals
- a directly correlated reduction in rehabilitation spend, which prevents rehabilitation providers from executing the above tasks.
  the deterioration in RTW rates, especially in 0-13 weeks post injury, results in over medicalisation rather than engagement through a biopsychosocial model of intervention

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

ARPA NSW have the following comments on implementation:

- On page 5 of the HOF ARPA would like to know who will be keeping the scorecard for the 'Quadruple Aim' and how will SIRA ensure that these aims are being met?
- The proposed framework states that one of the themes is "the importance of strengthening insurer controls over health provider billing". ARPA believes that instead of focussing controlling costs, that regulators should ensure best practice is implemented with regards to timely approval of services (and referral to WRPs), which would see improve return to work rates and therefore will lead to less medical costs.
- The plan needs to involve consultation from all stakeholders – stakeholders need to work with SIRA to work out the pragmatic steps required to have this framework work.
- Consultation is required on an ongoing basis to improve and promote the achievement of value-based care.
- The HOF should align (wherever possible) with the National Safety and Quality Health Service (NSQHS) Standards which have been developed by the Australian Commission on Safety and Quality in Health Care in collaboration with the Australian Government, states and territories, private sector providers, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. The eight NSQHS Standards provide a nationally consistent statement about the level of care consumers can expect from health services. See https://www.safetyandquality.gov.au/standards/nsqhs-standards