Principles of Best Practice in Occupational Rehabilitation for AIA Australia

Petrina Casey in consultation with
Professor Ian Cameron

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Petrina is the founder of Cortex Solutions who work with clients in the areas of personal injury, workplace health and disability management. Their focus is turning data, client experience and research into knowledge that can be used to improve claims, injury management and business outcomes.

Since 2010 she has been involved in developing the curriculum and teaching the Master of Management (Personal Injury) program offered by the Personal Injury Education Foundation. Petrina is a Member of the Deakin University Business School Personal Injury Advisory Board and was recently appointed a Member of the Safe Work Australia Expert Work Health and Safety and Workers Compensation Panel.

She holds a Master in Public Health and is currently completing her doctorate where the focus of her research is on the impact of compensation on health, social and RTW outcomes.

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The authors were commissioned by AIA Australia Limited (AIA Australia) to develop a principles based best practice occupational rehabilitation framework (The Best Practice Framework) to guide AIA Australia's occupational rehabilitation services. The views expressed are the authors and may not reflect the views of AIA Australia.

Foreword

By Damien Mu, Acting Chief Executive Officer, AIA Australia

Although it might not always feel like it, the evidence shows that work is actually good for our health.

For most people, being at work provides a sense of purpose in life and pushes us to greater heights and endeavours. It helps support the lifestyle we want to have, makes us happy, and is a major determinant of our overall health.

Being out of work can have the opposite effect. Long-term work absence due to injury, disability or a mental illness can be crippling. It not only impacts on earning ability, but it can drain an employee's confidence, identity and self-esteem in the process.

Returning to work following a physical injury, illness or a mental problem can be one of the best treatments to improve the health of employees. As life insurance specialists trusted to protect more than three million Australian lives, AIA Australia is committed to helping people return to work, where the condition permits.

Across the life insurance industry, the implementation of occupational rehabilitation and return to work programs for employees have made a considerable difference in helping employees get back to work. At AIA Australia, we have helped over 3,000 people to return to work in the last two years[1].

When implemented correctly, the benefits of occupational rehabilitation aren't just limited to the employee returning to work. The results show that it can help to improve claims management right across the industry by reducing the duration of claims, providing greater member benefits, as well as reducing the cost for life insurers, super funds and employers. It is a win-win-win situation.

While there have been successes in helping people return to work, there has been little outside guidance to life insurers about what makes 'best practice' in occupational rehabilitation. Traditionally, life insurers have compared their own offering with that of their competitors to determine best practice, regardless of whether this was actually right for rehab recipients and their providers.

To help raise the bar on how claims are managed across the industry, AIA Australia has commissioned the following research with renowned personal injury management and rehabilitation expert Petrina Casey. Entitled '*Principles for Best Practice in Occupational Rehabilitation*', the research draws on data collected from previous best practice research from around the world, return to work data, rehabilitation practitioner and employer research, as well as qualitative insights from claimants who have experienced the rehabilitation and return to work process.

We hope this research will provide great value for insurers, funds and intermediaries on how to deliver better results for employees engaging in return to work programs, and I want to thank Petrina for her commitment to this project.

The reality is that work is good for our health. The opportunity now exists for our superfund partners and Australian companies to play a leading role in helping employees get back to work following illness or injury. It's up to the life insurance industry to educate funds and companies on how they can best support RTW practices, ensuring their absence from work doesn't have a perpetuating effect.

1 Between 01/01/2012 – 31/12/2013

Executive Summary

The aim of the principles-based best practice occupational rehabilitation framework (The Best Practice Framework) is to provide an evidence-based approach to the provision of occupational rehabilitation services in the life insurance industry.

The Best Practice Framework is based on contemporary research evidence and outlines six principles to guide the life insurance industry's occupational rehabilitation services.

It has been established to:

- provide a set of guiding principles for the provision of occupational rehabilitation;
- minimise work disability for partners and customers;
- ensure occupational rehabilitation services are evidence-based;
- provide an evidence base for policy development and operational excellence in occupational rehabilitation service provision; and
- facilitate an understanding of the current approach AIA Australia has in place.

The Best Practice Framework recognises that underpinning the principles is an evidence-based platform. There are four key areas that support the effective implementation of a best practice approach, including:

- Building partnerships in return to work (RTW) practice;
- Operational policies and procedures aligned to best practice;
- Proactive, outcome-focussed allied health provider arrangements; and
- Building staff capability in RTW practice.

AIA Australia's customers and partners range from superannuation and corporate funds, intermediary organisations, employers and individual policy holders. Whilst the recipient of the occupational rehabilitation support or intervention is the claimant, the Best Practice Framework recognises the leadership role AIA Australia can have in assisting their customers and partners to understand best practice occupational rehabilitation, the importance of the workplace[2] in achieving RTW outcomes and the health benefits of work[3].

1 Australasian Faculty of Occupational Environmental Medicine AFOEM. 2010. Helping People Return to Work: Using evidence for better outcomes. A Position Statement.
3 Australasian Faculty of Occupational and Environmental Medicine AFOEM 2011. Australia and New Zealand Consensus Statement on the Health Benefits of Work. Position Statement: Realising the Health Benefits of Work.

The Best Practice Principles

1. Work is good for health and business
2. Screening: part of a strategic claims management process
3. Claimants are supported and empowered
4. Support the right intervention at the right time
5. Communicate, collaborate and educate effectively
6. Focus on outcomes

The Best Practice principles highlight that effective rehabilitation requires more than just a rehabilitation team.

1. Contents

1. Introduction 5

2. Background 5

3. The Best Practice Framework 6

4. The Health Benefits of Work 6

5. An evidence-based approach 7

6. The role of AIA Australia 9

7. Translating Best Practice 10

Principle 1 12

Principle 2 12

Principle 3 13

Principle 4 14

Principle 5 15

Principle 6 15

In summary 16

1. Introduction

This document outlines The Best Practice Occupational Rehabilitation Framework (The Best Practice Framework) for the provision of occupational rehabilitation services by AIA Australia. The Best Practice Framework is based on contemporary research evidence. It outlines six principles to guide AIA Australia's occupational rehabilitation services.

It has been established to:

- provide a set of guiding principles for the provision of occupational rehabilitation;
- minimise work disability for AIA Australia partners and customers;
- ensure occupational rehabilitation services provided are evidence based;
- provide an evidence base for policy development and operational excellence in occupational rehabilitation service provision; and
- facilitate an understanding of the current approach AIA Australia has in place.

2. Background

The evidence suggests that most people with injuries and illnesses and initial work incapacity recover in a predictable manner and return to work (RTW) without delay. However, for some the path is complicated and barriers to RTW are encountered[4]. Numerous potential barriers have been identified in the literature[5] and as time progresses the chances of these barriers having a negative impact increase and the likelihood of RTW decreases[6].

The support for early intervention is strong. It is one of the most effective 'measures against long-term benefit dependence'

Prolonged work incapacity is influenced by social, psychological and economic factors[7]. The current evidence supports a biopsychosocial approach in facilitating recovery and RTW while minimising the risk of long-term disability and persistent pain[8]. The support for early intervention is strong. It is one of the most effective 'measures against long-term benefit dependence'[9].

However, where early intervention may not be available, many people with common injuries and health problems can be helped to RTW by following the best practice principles outlined in this paper, which includes healthcare and having the right workplace management strategies in place[10].

Unlike other personal insurance arrangements, such as workers compensation or traffic accident insurance, those purchasing or accessing their life insurance policies (employers or claimants) have no procedural or legislative obligation to engage in or support the RTW process. However, RTW should be a key outcome for all who have work incapacity and a measure of success for insurers regardless of the cause. In fact, the flexibility of rehabilitation services in the life insurance sector can help where other arrangements may cease or be limited, representing an opportunity for the life insurers in helping people return to work. The consequences of this group not returning to work are wide ranging. It has a negative impact on the claimant, employers and contributes significantly to insurance and community costs.

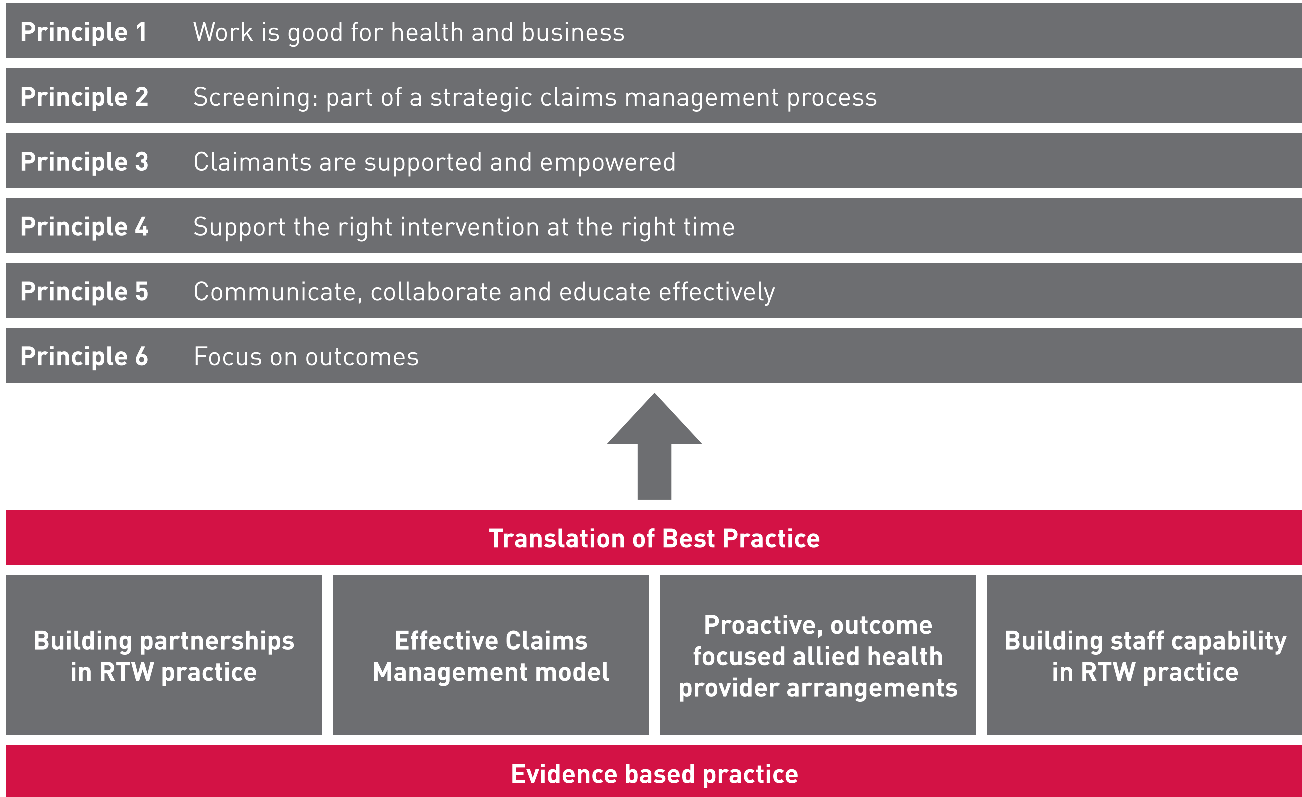
The focus should be to build partnerships where there is a shared understanding of best practice occupational rehabilitation, the importance of the workplace in achieving RTW outcomes and the health benefits of work.

This approach is supported by the evidence where it is suggested that occupational rehabilitation should be underpinned by 'education to inform the public, health professionals, and employers about the value of work for health and recovery'[11].

4 MacEachen, E, Kosny, A, & Ferrier, S. 2007. 'Unexpected barriers in return to work: lessons learned from injured worker peer support groups', Work, 29, 2, pp. 155–164.
5 Foreman, P, Murphy, G & Swerissen, H. 2006, Barriers and facilitators to return to work: A literature review. Australian Institute for Primary Care, La Trobe University, Melbourne.
6 Australasian Faculty of Occupational and Environmental Medicine AFOEM, October 2011. Australian and New Zealand Consensus Statement on the Health Benefits of Work. Position Statement: 'Realising the Health Benefits of Work'.
7 Krause N, Ragland D, Fisher J, Syme S. 1998. Psychosocial job factors, physical workload, and incidence of work-related spinal injury: a 5-year prospective study of urban transit operators. Spine 23(23):2507±2516.
8 Transport Accident Commission (TAC) and WorkSafe Victoria. 2012. Clinical Framework for the Delivery of Health Services.
9 OECD. 2003. Transforming disability into ability. Policies to promote work and income security for disabled people. The Organisation for Economic Co-operation and Development, Paris.
10 Waddell, A, Burton, K, Nicholas AK, Kendall AS, 2008. Vocational Rehabilitation What works, for whom, and when?.Department of Work and Pensions, U.K. ISBN 978-0-11-703861.
11 Waddell, G, Burton, K, Nicholas AK, Kendall AS, 2008. Vocational Rehabilitation, What works, for whom, and when? Department of Work and Pensions, U.K. ISBN 978–0–11–703861.

3. The Best Practice Framework

In addition to outlining the best practice principles for occupational rehabilitation, the Best Practice Framework recognises that underpinning the principles is an evidence-based platform. There are four key areas that support the effective implementation of a best practice approach in an insurance claims management environment.



4. The Health Benefits of Work

There is strong evidence that work is beneficial for health and social wellbeing and for most people work participation is an important part of participating in life[12].

'The evidence is compelling: for most individuals working improves general health and wellbeing and reduces psychological distress. Even health problems that are frequently attributed to work, for example, musculoskeletal and mental health conditions have been shown to benefit from activity based rehabilitation and an early return to suitable work' (AFOEM, 2011, pg7)[13].

12 World Health Organisation. International Classification of functioning, disability and health: ICF. 2001. Geneva: World Health Organisation.
13 Australasian Faculty of Occupational and Environmental Medicine AFOEM, October 2011. Australian and New Zealand Consensus Statement on the Health Benefits of Work. 'Realising the Health Benefits of Work'.

5. An evidence-based approach

A review of known relevant peer review journals and industry based publications was undertaken and the Best Practice Framework developed. It should be noted that there are few specific life insurance publications to draw from therefore the information presented draws from the general RTW literature which spans many disciplines. A particularly relevant source of evidence comes from the workers compensation literature where RTW is a key objective and the application of RTW support is in an insurance claims management context. In addition, a lot of the current knowledge on work related disability comes from the literature on musculoskeletal injuries, most commonly back injuries, which account for most of the work related injuries in industrialised countries.

Whilst musculoskeletal injuries/illness accounts for most of the claims, cancer and mental illness are also significantly represented. As cancer survival rates increase more people with cancer are returning to the workplace[14] and most recovered cancer patients can return to their previous employment[15]. Establishing work capacity, understanding their desire to work and any barriers to continuing or returning to work should be explored with those with cancer. Similar to those with musculoskeletal injury/illness, for those with mental health conditions the evidence supporting workplace-based and work focused programs is strong[16].

There is a strong evidence base supporting workplace-based rehabilitation, which can be more effective than clinic based treatment for RTW[20].

The Best Practice Framework outlines an approach to facilitating RTW outcomes that is applicable to those who have a potential capacity to work regardless of their injury or illness.

For the purpose of the Best Practice Framework

> ***work incapacity*** has been defined as 'reduced capacity and restriction of functioning in an occupational context' (Waddell & Burton, 2004, pg13)[17] and
>
> ***occupational rehabilitation*** has been defined as 'whatever helps someone with a health problem or injury to stay at, return to and remain in work: it is an idea and an approach as much as an intervention or a service' (Waddell et al., 2008, pg6)[18].

Many people can and do continue to work with health, illness and injury related problems, but better clinical and occupational management should aim to minimise the impact these problems have on work performance and productivity[19].

There is a strong evidence base supporting workplace-based rehabilitation, which can be more effective than clinic based treatment for RTW[20].

This leads to a focus on occupational management of injury and illness at the workplace which is about preventing persistent and disabling consequences[21] of injury and illness and implementing strategies focused on recovering at work[22].

Regardless of whether the injury or illness is physical or psychological in nature, claims management experience shows that return to work outcomes are improved where:

- an employee perceives that their work is valued;
- management is committed to the return to work effort (such as finding suitable duties); and
- there is peer support on return to the work group[23].

The implementation of workplace strategies, however, may need to consider the person's underlying injury or illness and should be tailored to the individual. For example, oncology patients may experience specific issues returning to the workplace, related to their site of disease and type of treatment. These could include fatigue, absences needed for treatment, and limitations in their ability to manage transportation, or work-related tasks, and these should be considered in the RTW strategy[24].

For those who are not 'attached' to an employer, or are self-employed, the complexity of providing workplace-based interventions increases. Employers can be hesitant to accept the redeployment or RTW of those where doubts exist concerning the level of work performance that they could achieve and when the potential

14 Peteet, JR. 2000. Cancer and the Meaning of Work. General Hospital Psychiatry Vol 22. 200–205.
15 Mellette SJ: The cancer patient at work. CA–A Cancer J Clinicians 35:360–373, 1985.
16 Pomaki, G., Franche, R., Khushrushahi, N., Murray, E., Lampinen, T., Mah, P. (2010). Best Practices for Return-to-work/Stay-at-work Interventions for Workers with Mental Health Conditions. Vancouver, BC: Occupational Health and Safety Agency for Healthcare in BC (OHSAH).
17 Waddell, G, Burton, K, 2004. Concepts of Rehabilitation for the Management of Common Health Problems. Printed in the United Kingdom for The Stationery Office, ISBN 0 11 703394.
18 Waddell, G, Burton, K, Nicholas AK, Kendall AS, 2008. Vocational Rehabilitation, What works, for whom, and when? Department of Work and Pensions, U.K. ISBN 978–0–11–703861.
19 Blyth FM,March LM, Nicholas MK, Cousins MJ. 2003. Chronic pain, work performance and litigation. Pain 103: 41–47.
20 Waddell, G, Burton, K, 2004. Concepts of Rehabilitation for the Management of Common Health Problems. Printed in the United Kingdom for The Stationery Office, ISBN 0 11 703394.
21 Shaw WS, Feuerstein M, Huang GD. 2002. Secondary prevention and the workplace. In New avenues for the prevention of chronic musculoskeletal pain and disability. Pain research and clinical management. Vol 12 (Ed. Linton SJ) : 215–235.
22 HSE. 2004. An employers and managers guide to managing sickness and recovery of health at work. Draft document.
23 Cotton, P., & Hart, P. M. (2003), 'Occupational wellbeing and performance: a review of organisational health research,' Australian Psychologist, vol. 38, no. 1, pp. 118–127.
24 Peteet, JR. 2000. Cancer and the Meaning of Work. General Hospital Psychiatry Vol 22. 200–205.

employee is not known to them their concern increases[25]. However the principles of engaging and educating employers to facilitate a RTW are the same regardless of whether the employee is returning to an existing or commencing with a new employer. Similarly, the principles of empowerment and motivation to establish a work capacity and a RTW outcome for many claimants will be the same whether 'attached' to an employer or not.

There is also a strong evidence base for early intervention, 'before long-term incapacity ever develops'[26]. In implementing appropriate and early intervention, understanding and giving due consideration to barriers or obstacles to RTW is important and many potential barriers have been identified in the literature[27].

The primary goal of occupational rehabilitation should therefore be to restore function and the focus should be on overcoming obstacles to RTW[28].

A recent systematic review of intervention characteristics that facilitate RTW regardless of the cause of injury or illness found that 'early and multidisciplinary intervention and time contingent, activating interventions appear most effective to support RTW'[29].

'...early and multidisciplinary intervention and time contingent, activating interventions appear most effective to support RTW'

The evidence suggests that the impact of risk factors and interventions vary according to the length of the period of disability. In this context disability phases are defined by duration of work incapacity and common cut off points are acute (up to 30 days off work), sub-acute (30–90 days off work) and chronic (more than 90 days). Whilst these phases are more readily applicable to those with musculoskeletal injury understanding the length of the disability phase and the appropriate interventions is important regardless of the injury.

In the early acute and sub-acute phases factors such as injury or illness severity, medical complications and medically required treatment are more likely to be associated with work incapacity. However, as the duration of disability increases, psychosocial risk factors like motivation are more likely to contribute to the incapacity.

To ensure outcomes are achieved interventions must be targeted to the phase of disability, i.e. someone in the acute disability phase will probably require a different intervention than someone in the chronic disability phase.

Whilst the likelihood of RTW decreases as the length of time away from work increases, it is not suggested that those with prolonged durations of disability do not benefit from rehabilitation, as they can achieve successful RTW outcomes[30]. For these people the evidence suggests that the service decision makers should prioritise 'tailored, systematically conducted assessments of people's needs for vocational rehabilitation and re-employment'[31].

In an insurance claims management context there is substantial support for implementing a screening process which identifies any barriers and informs the allocation of cases, usually to skilled staff or to external providers based on the level of risk associated with the case[32,33]. Drawing from the research in injury compensation schemes, scheme participants reported better satisfaction levels and found the case management service itself more beneficial when they were treated as an individual[34]. They were more likely to be satisfied and successful in overcoming barriers to RTW and recovery when case managers were good communicators and when they had relationships with knowledgeable and approachable service providers who listened to them[35]. This research underpins the importance of building staff capability and capacity in RTW practice.

RTW is a complex and multi-factorial/multi-dimensional problem for a certain proportion of claimants[36]. Persistent work disability and RTW are not uniquely biomedical outcomes, they are processes that are influenced by social, psychological and economic factors[37].

25 James. P. et al, 2006 Job retention and return to work of ill and injured workers: Towards an understanding of the organisational dynamics. Employee Relations Vol. 28 No. 3, 2006,pp. 290–303.

26 OECD. 2003. Transforming disability into ability. Policies to promote work and income security for disabled people. The Organisation for Economic Co-operation and Development, Paris.

27 Foreman, P, Murphy, G &Swerissen, H. 2006, Barriers and facilitators to return to work: A literature review. Australian Institute for Primary Care, La Trobe University, Melbourne.

28 Australasian Faculty of Occupational and Environmental Medicine AFOEM 2011. Australia and New Zealand Consensus Statement on the Health Benefits of Work. Position Statement: Realising the Health Benefits of Work.

29 Hoefsmit, N. 2012 Intervention Characteristics that Facilitate Return to Work After Sickness Absence: A Systematic Literature Review. Journal of Occupational Rehabilitation Volume 22, Issue 4, pp 462-477.

30 Jordan, K.D et al. Should Extended Disability Be an Exclusion Criteria for Tertiary Rehabilitation. 1198. 998. Spine. Volume 23, Number 19.2110-2117.

31 Juvonen-Posti, P. 2004. The reality of returning to work and training: experiences from a long-term unemployment project International Journal of Rehabilitation Research 2004, Vol 27 No 3.

32 PWC, 2011, Vocational Rehabilitation Framework-Model Options. Final Report. Prepared for WorkCover SA.

33 Booz and Co., 2008. Personal Injury Claims Best Practices. Better Choices Better Health Conference. Adelaide, Australia. 24 25 November 2008.

34 Brines, J, Salazar, MK, Graham, KY, Pergola, T and Connon, C 1999, 'Injured workers' perceptions of case management services' AAOHN Journal, Vol. 47, No. 8,pp. 355-364.

35 Shaw, L, MacKinnon, Mc William, C and Sumsion T 2004. 'Consumer participation in the work rehabilitation process: Contextual factors and implications for practice', Work Vol, 23, pp.181–192.

36 Ikezawa, Y, Battié, M, Beach, J, & Gross, D 2010, 'Do Clinicians Working Within the Same Context Make Consistent Return-to-Work Recommendations?', Journal of Occupational Rehabilitation, 20, 3, pp. 367-377.

37 Krause N, Ragland D, Fisher J, Syme S. 1998b. Psychosocial job factors, physical workload, and incidence of work-related spinal injury: a 5-year prospective study of urban transit operators. Spine 23(23):2507±2516.

The current evidence indicates that the biopsychosocial approach to managing injuries is effective in facilitating recovery and RTW while minimising the risk of long-term activity limitation, participation restriction, or persistent pain[38].

According to the biopsychosocial model, work may confer many benefits including:

- Ensuring that some physical activity is undertaken on work days;
- Providing a sense of community and social inclusion;
- Allowing workers to feel that they are making a contribution to society and their family;
- Giving structure to days and weeks;
- Financial security; and
- A decreased likelihood that individuals will engage in risky behaviours, such as excessive drinking (AFOEM, 2010, pg8)[39].

In summary, the principles outlined in the Best Practice Framework are applicable to all those who have a potential work capacity, regardless of the cause of the injury or illness, their employment status or the length of the claimant's disability at the time of lodging a claim.

6. The role of AIA Australia

AIA Australia provides personal insurance coverage to 20% of the Australian working population and a significant proportion of this is for disability and income protection insurance products[40]. The relationship AIA Australia has with the person (the claimant) who ultimately accesses the insurance product (and may require occupational rehabilitation assistance) can be influenced by how the insurance policy was purchased. Whilst this may present challenges in implementing a best practice approach, the principles of good occupational rehabilitation is consistent regardless of how the insurance coverage was purchased.

It is within an insurance claims management context that AIA Australia provides occupational rehabilitation support and intervention. Therefore it is relevant to consider the research that suggests compensation factors can impact on health and RTW outcomes[41] and that non-adversarial handling of claims and sympathetic communication with the claimant are as important as appropriately modified work which matches the injured workers' physical capacities, in providing a comprehensive disability management intervention[42].

Claims management in the personal injury sector has been defined as the

> "Integration of injury management and claims administration, with the aim of returning people to health and work."[43]

This is an appropriate definition to use within the life insurance context and the Best Practice Framework recognises the importance of the alignment between the claims management model and the rehabilitation process in influencing RTW outcomes[44].

> *'Persistent work disability and RTW are not uniquely biomedical outcomes, they are processes that are influenced by social, psychological and economic factors.'*

38 Transport Accident Commission (TAC) and WorkSafe Victoria. 2012. Clinical Framework for the Delivery of Health Services.

39 Australasian Faculty of Occupational and Environmental Medicine AFOEM, October 2011. Australian and New Zealand Consensus Statement on the Health Benefits of Work. 'Realising the Health Benefits of Work'.

40 AIA Australia 2014 'About AIA, AIA Australia', http://www.aia.com.au/en/about-aia/about-us/aiaa/

41 Harris, I, Mulford J, Solomon M, van Gelder J, Young JY 2005 'Association between compensation status and outcome after surgery: A meta-analysis', JAMA, Vol. 293, No. 13, pp. 1644-1652.

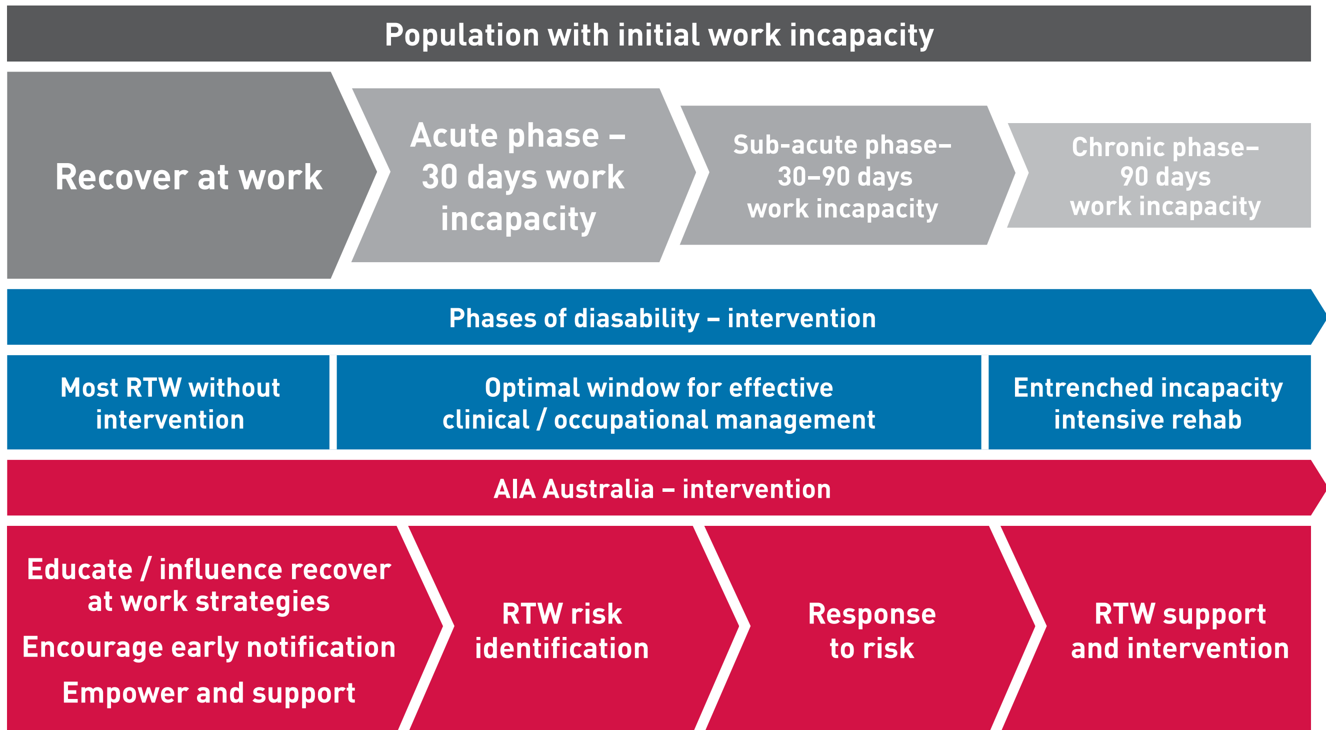
42 Frank, J and Cullen, K and the IWH Ad Hoc Working Group 2003. Preventing Injury, Illness and Disability at Work: What Works and What do we know?, A Discussion Paper for Ontario's Occupational Health and Safety Community.

43 Francis C et al. 2009. Accident Compensation Claims Management – Lessons Learnt and Claimant Outcomes. The 12th Accident Compensation Seminar, Melbourne, Australia.

44 PWC, 2011, Vocational Rehabilitation Framework-Model Options. Final Report. Prepared for WorkCover SA.

Figure 1 represents the role of AIA Australia in the RTW continuum.

Figure 1 AIA Australia activity in the RTW continuum



7. Translating Best Practice

Building partnerships in RTW practice: There is strong evidence supporting many aspects of occupational rehabilitation.

Successful rehabilitation outcomes are more likely when the support and interventions are work focussed and coordinated with the workplace[45].

Additionally there has been increasing interest in helping people to stay at work or recover at work recognising that it is better and easier to prevent unnecessary sickness absence rather than deal with them after they occur.

RTW practice not only includes workplace strategies. Communication, collaboration, education, application of a biopsychosocial approach are all key RTW practices. This is particularly important where claimants are not attached to an employer, highlighting the need to build successful partnerships with occupational rehabilitation providers who are skilled in achieving a work capacity for those who are unemployed and/or returning claimants to work with new employers. Building partnerships in RTW practice is about educating all the parties in the RTW process about best practice.

Effective claims management model: For occupational rehabilitation services to be successful it must be supported by an effective claims management model. A review of 'best practice' claims management organisations suggests that there are five 'must haves' to achieve 'best practice' in claims management. They consider the following components to be critical: greater customer focus, proactive claims management, focused people strategies, more sophisticated use of data and an active allied health provider management framework[46].

A proactive and customer centric approach is one where the requirements of stakeholders are anticipated and met in a timely fashion. Most organisations in the personal injury environment view the claimant as an important customer even though they are often not the purchaser of the insurance policy and many have moved away from using the term 'claimant' to 'customer' to better reflect a customer centric approach.

In addition to suitably qualified and engaged staff, case loads should allow claims managers time to be proactive. If case loads are too high then claims handlers cannot

45 Waddell, G, Burton, K, Nicholas AK, Kendall AS, 2008. Vocational Rehabilitation, What works, for whom, and when? Department of Work and Pensions, U.K. ISBN 978-0-11-703861.

46 Booz and Co., 2008. Personal Injury Claims Best Practices. Better Choices Better Health Conference. Adelaide, Australia. 24 25 November 2008.

be proactive[47]. In addition to appropriate case file loads, many organisations have been reviewing their technology platforms in recognition that enhanced automation and workflow tools that facilitate screening is necessary to be proactive in their claims management approach.

People and culture are critical enablers of a best practice approach for any organisation. Implementing sophisticated claims management and workflow technology systems alone will not deliver successful outcomes.

Traditionally competency requirements for claims managers were largely based on technical elements. There is now a recognition that claims managers must be competent in the areas of negotiation, decision making and communication. In addition to recruiting and retaining the right staff, best practice has been identified as ensuring that the right staff member is managing the right claim. For example, claims with complex medical issues are managed with input from allied health professionals, claims with complex policy or eligibility issues are managed by appropriately qualified legal or technical staff.

Implementing sophisticated claims management and workflow technology systems alone will not deliver successful outcomes.

Claim segmentation in accordance with staff skill and capability is considered a cornerstone of effective claims management.

To ensure the Best Practices are implemented, the policies and procedures that guide claims and rehabilitation staff in the RTW process should be aligned to the principles. Defining and communicating standardised process relevant to RTW, so they may be easily understood and applied by claims and rehabilitation staff is a key consideration in the effective translation of best practice into effective action[48].

Proactive, outcome focussed allied health provider arrangements: Health professionals are a key stakeholder in the RTW process and have considerable influence on work absence and work disability, particularly in relation to work capacity certification advice and practices[49]. In the RTW process contact is essential with many different health providers, for example, general practitioners, occupational consultants, physiotherapists, psychologists, workplace rehabilitation providers and outcomes can vary dependent on the quality of the health and disability providers involved.

Evidence from organisations considered to be best practice in this area suggests that organisations who work in partnership with their contracted/engaged allied and medical health providers to achieve outcomes are more successful[50]. Provider management arrangements should specify the service model delivery, reporting requirements, performance, service standards and target levels and incentives. Arrangements should also specify the minimum skill level and expertise to carry out specialist services.

Building staff capability in RTW practice: Proactive management of work related issues which support a claimant requires a high level of skill to ensure the right interventions are applied at the right time[51]. In addition, having a culture of professional development and accountability are considered key elements in the effective translation of best practice into effective action[52].

It is important that all claims managers understand the philosophy of the RTW Framework which is based on the 'Work is good for health and business' philosophy. Claims managers need to be well-informed regarding the detrimental impact of long-term work incapacity upon an individual's overall wellbeing and to have an understanding of the evidence supporting the association between work and health.

Claims managers are required to be competent in setting expectations, empowering the injured person, educating and influencing RTW stakeholders and implementing sound decisions to influence RTW outcomes.

It is also important for them to understand their role as the first port of call for claimants in screening for rehabilitation and RTW services and establishing the right level of engagement.

47 Rose, P., and Cutter, A., (2007) "Technical Development of Appropriate Claims File Loads", presented at the Institute of Actuaries of Australia 21st Accident Compensation Seminar, April 2007.
48 Francis C et al. 2009. Accident Compensation Claims Management – Lessons Learnt and Claimant Outcomes. The 12th Accident Compensation Seminar, Melbourne, Australia.
49 Australasian Faculty of Occupational and Environmental Medicine AFOEM, October 2011. Australian and New Zealand Consensus Statement on the Health Benefits of Work. 'Realising the Health Benefits of Work'.
50 Booz and Co., 2008. Personal Injury Claims Best Practices. Better Choices Better Health Conference. Adelaide, Australia. 24–25 November 2008.
51 Bracton Consulting Services Pty Ltd & PricewaterhouseCoopers. 2007. Review of the South Australian Workers' Compensation System Report, South Australia, Australia.
52 Francis C et al. 2009. Accident Compensation Claims Management – Lessons Learnt and Claimant Outcomes. The 12th Accident Compensation Seminar, Melbourne, Australia.

Principle 1

Work is good for health and business

It is essential for the industry to understand the 'Work is good for health and business' philosophy. This will assist people to recover at work, encourage early claim notification and early intervention. When claims are lodged employers will be educated on the benefits of early RTW for the claimant and for their business.

This may require some innovative approaches in education and mentoring. The provision of this education is more important where there is a significant delay from injury to claim lodgement as this reduces the opportunity to provide early intervention within what is considered the optimal window of opportunity for effective clinical / occupational management[53]. Through education, life insurers should aim to influence earlier notification of claims and/or encourage employers to act within the optimal time frame.

In the US some disability insurers are offering integrated absence management services in response to employers who are focused on absence management and productivity rather than on claim management or reduction in claims. The focus of these absence management programs are on addressing the workplace issues causing absence and ultimately causing disability claims, early intervention to reduce absence duration, reoccurrences and optimise RTW outcomes[54].

Successful rehabilitation outcomes are more likely when the support and interventions are work focussed and coordinated with the workplace.

53 Waddell, G, Burton, K, 2004. Concepts of Rehabilitation for the Management of Common Health Problems. Printed in the United Kingdom for The Stationery Office, ISBN 0 11 703394.

54 Dunnington K. Absence Management: Improving Health to Reduce Absence, CIGNA . AVP, Wellness, Absence & Productivity. Society of Actuaries , 2010 Annual Meeting & Exhibit Oct. 17-20, 2010.

Principle 2

Early screening: part of a strategic claims management process

An operational model that has strong 'linkages between claims management activity and rehabilitation' is essential[55].

This involves clear protocols for referral to internal rehabilitation staff and for referral to external occupational rehabilitation providers. This should include clear protocols and a decision making model for assessing those who are eligible for RTW support and assistance (based on injury /illness severity or policy restrictions). It is important to consistently recognise those with RTW potential as not everyone lodging a claim will have a capacity to work (and identifying this group is important to avoid putting in place inappropriate services).

Once a potential RTW capacity is established, an early screening or risk assessment approach is required to identify any barriers to RTW and understand the type of interventions required. This risk assessment approach should consider the risks across the biological, psychosocial and social domains (a biopsychosocial approach)[56]. Increasingly, research has shown the important role psychosocial factors play in recovery and claim outcomes. Studies have found factors like motivation, attitudes and perceived ability/expectation to RTW, self-reported pain, catastrophising and poor coping skills impact recovery and delayed or non RTW[57]. Consistent with this research, disability insurers recently reported that claimant motivation was the biggest determinant of rehabilitation utilisation and RTW[58].

Initially risk factors can be identified according to the flags model which describes the factors that can have an impact on RTW and recovery. This approach is effective in understanding the general risks of prolonged disability. However, it does not enable targeted treatment and RTW programs to be developed[59]. Therefore, for those

55 PWC, 2011, Vocational Rehabilitation Framework-Model Options. Final Report. Prepared for WorkCover SA.

56 Dunstan DA, Covic T. 2006. Compensable work disability management: A literature review of biopsychosocial perspectives. Australian Occupational Therapy Journal, Vol.53, pp. 67–77.

57 Foreman P, Murphy, G, and Swerissen, H. 2006. Barriers and facilitators to return to work: A literature review. Australian Institute for Primary Care, La Trobe University, Melbourne.

58 RGA Global Surveys. 2012. Speciality Rehabilitation Services And Disability Insurance: A Global Analysis of Utilization and Value.

59 Stratil R and Swincer M, 2012. Work-related back pain study: measuring biopsychosocial risk factors Discussion paper prepared for WorkCover SA.

with risk factors a targeted or comprehensive screening process should be adopted to identify the specific issues preventing RTW. This should be done in conjunction with the injured person's treating practitioner and may involve administering a more comprehensive screening tool aimed at identifying specific risk factors such as, pain, functional issues, readiness to RTW or ongoing psychological issues. The information from this process should then be utilised in a tailored RTW strategy and RTW plan. It also allows understanding of barriers that can be influenced or changed and identifies claimants who need motivational support, particularly those who have prolonged periods of work absence.

The claimants' circumstances may change, so a process that continuously assesses the risk of work incapacity is necessary (systematic).

Principle 3

Claimants are supported and empowered

The evidence supports reassurance and encouragement to resume normal activities, including work, to be effective in optimising RTW outcomes[60]. Case managers that display empathy can strengthen the quality of the relationship with the claimant through the provision of support and guidance through the RTW process.

Disability insurers recently reported that claimant motivation was the biggest determinant of rehabilitation utilisation and RTW.

Communication should focus on educating, setting expectations around the RTW process and empowering the injured person to manage their RTW journey. Good RTW outcomes are more likely when individuals understand the health benefits of work and are empowered to take responsibility for their own situation.

The research supports 'empowerment' as a key component of a successful RTW program[61]. Understanding the coping mechanisms and self-management strategies the injured person has in place, as well as encouraging new ones, will increase the likelihood of a successful RTW. For example, in the context of chronic disease management, 'self–management' strategies have been defined as 'strategies that enable people to minimise their symptoms, share in decision-making about their treatment and gain a sense of control over their lives despite their chronic condition'[62].

Disability insurers recently reported that claimant motivation was the biggest determinant of rehabilitation utilisation and RTW[63].

For the long term unemployed the research suggests that motivation to RTW is one of the key determinants[64]. The research supports using 'motivational interviewing' techniques, particularly with those who remain off work longer than expected[65]. Some organisations providing claims management services such as the Transport Accident Commission (TAC) in Victoria have trained staff in this approach and report its effectiveness in assisting in the RTW process[66].

60 Australasian Faculty of Occupational and Environmental Medicine AFOEM, October 2011. Australian and New Zealand Consensus Statement on the Health Benefits of Work. 'Realising the Health Benefits of Work'.
61 Ammendolia, C., D. Cassidy, et al. 2009. Designing a workplace return-to-work program for occupational low back pain: an intervention mapping approach. BMC Musculoskeletal Disorders, Vol 10, No 1. p 65.
62 Lorig KR, Holman HR. Self-management education: History, definition, outcomes and mechanisms. Ann Behavioral Med 2003;26(1):1–7.
63 RGA Global Surveys. 2012. Speciality Rehabilitation Services And Disability Insurance: A Global Analysis of Utilization and Value.
64 Wren, 2011.
65 ISCRR. Use of Motivational Interviewing by Non-Clinicians in Non- Clinical Settings: Report No. 22-021.
66 Poel D and Pocock N 2013. TAC Claims Management Transformation – The Journey Continues. Presented to the Actuaries Institute Injury Schemes Seminar 10–12 November 2013.

Principle 4

Support the right intervention at the right time

Understanding the claimant's circumstances and expectations with respect to their capacity to work following an injury or illness as soon as possible is important. This informs the appropriate intervention required and establishes a clear pathway for those who will RTW without specific interventions (but may need support and encouragement) and those with RTW risks requiring intervention.

Consideration of the disability phase of the injury is important in ensuring the right intervention is implemented. For example in the acute disability phase, interventions aimed at pain relief, advice to remain active, that is, to participate in everyday activities, including remaining at or returning to work, as soon as possible are appropriate. For those in the chronic disability phase, interventions would typically be more intensive usually involving specialist rehabilitation where multidisciplinary biopsychosocial rehabilitation has been shown to be effective.

Regardless of phase of disability, the current evidence indicates that the biopsychosocial approach to managing injuries is effective in facilitating recovery and RTW while minimising the risk of long-term activity limitation, participation restriction, or persistent pain[67]. This ensures that the claimant is viewed holistically, programs are tailored to the claimant's needs and return to work is promoted as a crucial part of the claimant's rehabilitation. For example, because of fatigue or other physical limitations cancer patients may need to consider a range of work options, including part-time employment or volunteering, both of which can have important positive consequences for individuals coming to terms with disability[68].

Intervention, if offered early, reduces the risk of long term work incapacity. In considering early interventions workplace-based rehabilitation should be a focus. It has found to be successful in reducing perceived pain and disability, improving functional capabilities and preventing further work disability[69]. Where possible interventions should be implemented as soon as possible, however, for claims that are lodged greater than six months post injury, the focus is on ensuring the right treatment or intervention is provided at the right time and by the right provider.

The motivation of the claimant and the duration of their disability are determinants of whether RTW will be successful. The evidence also suggests that the direct engagement of employers in development of tailored programs for the long-term unemployed is one of the most effective ways of motivating participants[70].

So, regardless of whether a claimant is attached to an employer, a key ingredient for RTW success is getting an employer on board. The evidence further suggests that service decision makers should prioritise 'tailored, systematically conducted assessments of people's needs for vocational rehabilitation and re-employment' for those with prolonged work incapacity[71].

'Claim segmentation in accordance with staff skill and capability is considered a cornerstone of effective claims management.'

67 Transport Accident Commission (TAC) and WorkSafe Victoria. 2012. Clinical Framework for the Delivery of Health Services

68 Peteet, JR. 2000. Cancer and the Meaning of Work. General Hospital Psychiatry Vol 22. 200-205.

69 Cheng and Hung. Randomized Controlled Trial of Workplace-based Rehabilitation for Work-related Rotator Cuff Disorder. J Occup Rehab (2007) 17:487-503.

70 Wren, T, 2011, "Lifting participation and employment for disadvantaged job seekers: Demand-led and supply-sensitive reforms", ACOSS National Conference, 29 March

71 Juvonen-Posti, P. 2004. The reality of returning to work and training: experiences from a long-term unemployment project International Journal of Rehabilitation Research 2004, Vol 27 No 3

Principle 5

Communicate, collaborate and educate effectively

Collaboration with the RTW stakeholders (employer, doctor, healthcare providers, family, other) is important in setting and aligning expectations and achieving RTW outcomes. In a recent global survey of disability insurers RTW success levels were highest for insurers using a partnership approach – that is, working and engaging with the claimant, his/her family, employer, medical advisors and providers[72].

Establishing and agreeing on the roles that the stakeholders will have in supporting the claimant in their RTW pathway is an important early step. An important component of successful RTW strategies ensures risks are identified from the perspectives of the various stakeholders and shared[73].

In addition to the evidence suggesting that most people rehabilitate effectively in the workplace it is recognised that employers who have a people orientated organisational culture, effective absence and injury management practices contribute to successful outcomes so contacting and engaging employers as soon as any risks are identified is critical. This is more likely to result in informed assistance in the RTW process. With the research supporting the involvement of the employer and their collaboration with the injured person as a key contributor to better RTW outcomes getting this engagement right is very important[74].

The research also suggests that healthcare providers should play an active role early in the process of RTW, this includes proactive communication with the patient and direct contact with their workplace[75]. When this occurs RTW is more successful. This can be facilitated by organising case conferences, which is also supported by the research as a key case management strategy. It facilitates communication and offers an opportunity to understand differences in opinion and perspective[76].

72 RGA Global Surveys. 2012. Speciality Rehabilitation Services And Disability Insurance: A Global Analysis of Utilization and Value.

73 Ammendolia, C., D. Cassidy, et al. 2009. Designing a workplace return-to-work program for occupational low back pain: an intervention mapping approach. BMC Musculoskeletal Disorders, Vol 10, No 1. p 65.

74 Tschernetzki-Neilson, P., E. S. Brintnell, et al. 2007. Changing to an Outcome-focused Program Improves Return to Work Outcomes. Journal of Occupational Rehabilitation. Vol 17, No3, pp 473-486.

75 Kosny, A, Franche, RL, Pole, J, Krause, N, Côté, P. and Mustard, C. 2006. 'Early healthcare provider communication with patients and their workplace following a lost-time claim for an occupational musculoskeletal injury.' Journal of Occupational Rehabilitation, Vol. 16, No. 1, pp. 27-39.

76 Franche, R., K. Cullen, et al. 2005. Workplace-based return-to-work interventions: a systematic review of the quantitative literature. Journal of Occupational Rehabilitation. Vol, 15, pp 607 - 631.

Principle 6

Focus on outcomes

There should be a focus on outcomes at the individual claim level, where appropriate outcome measures are captured and used to evaluate the effectiveness of the occupational rehabilitation services provided.

At the individual claim level, referral for appropriate RTW assessment and vocational interventions should occur at the right time and address any identified barriers. Consideration of any necessary supports or interventions should focus on outcomes. They should consider the needs of the claimant and the employer's circumstances where the focus is on recovering at work.

Interventions should be evidence-based, planned with a clear goal, reviewed regularly and amended as appropriate. Realistic RTW goals should be agreed to by the claimant, deemed appropriate by the RTW stakeholders and supported by documented evidence such as the medical fitness for work certificate. Specific objectives should be jointly established to support the injured person to work towards their goal.

An outcome focussed RTW plan that is developed in consultation with the claimant and the key RTW stakeholders (for example, employer and treating practitioners) is key to achieving RTW outcomes.

The aim of RTW plans has been defined as a necessary means 'to gradually increase the tolerance of an injured worker using suitable duties, or those duties suitably matched to the employee's capacity, to enable a return to pre-injury duties'[77].

With research evidence affirming that the best place for most people to rehabilitate following an injury is in the workplace[78], it is important that the RTW plan reflect this with development of goals specific to the workplace. Where there is no workplace involved /available initially, the interventions or strategies to achieve a work capacity or RTW may be different, for example it may include education, retraining, job seeking or counselling - however these should have clear RTW outcomes articulated and agreed to by the claimant. Without outcome focused RTW plans achieving RTW outcomes may be compromised.

77 Sager L, James C, 2005. Injured workers' perspectives of their rehabilitation process under the New South Wales Workers Compensation System Australian Occupational Therapy Journal, Vol 52,pp 127–135.

78 Institute for Work and Health. 2007. The Seven Principles for Successful RTW.

In summary

The evidence is compelling: for most individuals working improves general health and wellbeing and reduces psychological distress.

Following injury and illness most people RTW but for some their path is complicated and RTW support and intervention is required. There are some specific challenges, for example late claim notifications and the many stakeholders in the group insurance context. The management of these claims tend to become more complex as time passes due to the negative consequences associated with long-term disengagement from the work role and prolonged functional incapacity. This highlights a key challenge for life insurers in the importance of a tailored and sophisticated approach to finding ways to reduce claim notification delays and identifying suitable candidates as soon as possible.

These principles remain the same regardless, recognising that the RTW support and interventions required will probably be more intensive where retraining and redeployment options will need to be explored. The research supports 'the constructive effects of positive events' such as re-employment[79]. Re-employment of unemployed adults has been found to be associated with improved general health and wellbeing, reduced psychological distress and improved physical functioning and mental health in older workers.

Unlike other personal injury insurance arrangements, such as workers compensation or traffic accident insurance, those purchasing or accessing their life insurance policies (employers or claimants) do not have a strict obligation to engage in or support the RTW process outside of general duties such as the utmost duty of good faith and to mitigate a loss. Having said that, an opportunity exists for the life insurance industry to add value in helping people return to work due to the flexibility of its rehabilitation services where other arrangements may be limited. This means that building effective relationships and developing meaningful systems and processes with all clients and customers, is critical to the success of rehabilitation in the life insurance context. Despite this and other challenges, RTW should be a key outcome for all who have work incapacity and a measure of success for insurers regardless of the cause.

The Best Practice Framework outlines a set of best practice principles for the provision of occupational rehabilitation services.

79 Bayoumi, A., Chambers, L., Lavis, J., Mustard, C., Raboud, J., Rourke, S.B., Rueda, S., & Wilson, M. (2012), 'Association of returning to work with better health in working-aged adults: a systematic review,' The American Journal of Public Health, vol. 102, no. 3, pp.541-56.

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