BODY STRESSING INJURIES

Key messages for rehabilitation providers

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BACKGROUND

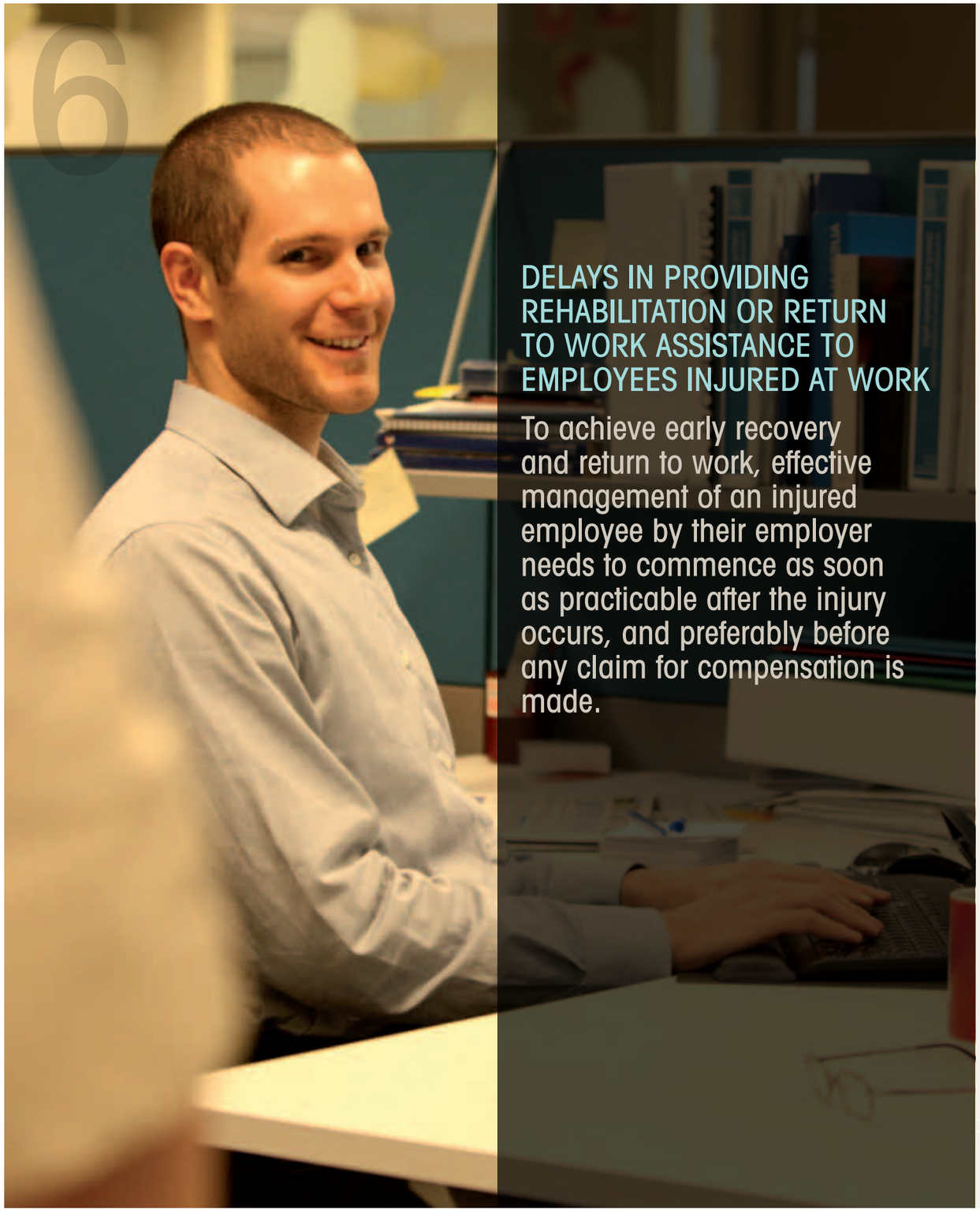
Body stressing injuries include a range of soft tissue injuries sustained through activities such as manual handling or repetitive movement.

These injuries are significant drivers of workers' compensation premiums for Australian and ACT Government premium-paying agencies. For these agencies in 2004–2005, claims for body stressing injuries accounted for 40.7 per cent of all workers' compensation claims and made up 45 per cent of the total cost of such workers' compensation claims.

Over recent years there has been a trend for employees injured at work to stay off work for longer periods. In many cases the time off work for a work-related body stressing injury is extending beyond the expected recovery period of 6–12 weeks, including in cases where the initial injury was apparently minor.

Comcare engaged SANO Consulting (SANO) to undertake a review of a sample of body stressing workers' compensation claims for Australian and ACT Government employees.

The research included a review of jurisdictional claims data, analysis of existing claims management systems processed in Comcare and agencies, meetings with key Comcare stakeholders, and structured telephone interviews with claimants, agency case managers and workplace rehabilitation providers (WRPs).



DELAYS IN PROVIDING REHABILITATION OR RETURN TO WORK ASSISTANCE TO EMPLOYEES INJURED AT WORK

To achieve early recovery and return to work, effective management of an injured employee by their employer needs to commence as soon as practicable after the injury occurs, and preferably before any claim for compensation is made.

Against this background, SANO assessed:

- the elapsed time between key intervention points—those being points in the timeline from date of injury through to the employee returning to work
- the activities of key stakeholders at these key points—key stakeholders such as the employer, Comcare, workplace rehabilitation providers and treatment providers
- the interactions between the key stakeholders
- risk factors for extended claims duration—that is, factors that increase the risk of the injury becoming chronic.

With appropriate injury management and treatment, the recovery times for body stressing injuries, including relatively severe soft tissue injuries, should be no more than 12 weeks (or 84 days), and in many cases no more than six weeks (or 42 days). Despite this, the research found that the average time taken from the date of injury to the date of first rehabilitation intervention for these injuries was 87 days for Australian Government agencies and 73 days for ACT Government agencies (2004–2005). For the claims in the SANO sample, it was 74 days. This means that, in most cases, assistance was not provided until after the normal recovery period for the injury. It also means that by the time assistance was provided, it was often no longer appropriate. This is because different forms of treatment and assistance are needed once a body stressing injury progresses beyond 12 weeks of incapacity and becomes a 'chronic' injury.

SANO's research identified the need to improve workplace culture and systems for reporting injuries so that injured employees can be provided with assistance at an earlier stage. This required employers to develop clear policies and guidelines for early intervention, and to allocate resources to enable early rehabilitation assistance. If intervention is made contingent upon the employee submitting a claim, or a claim being accepted by Comcare, then opportunities for recovery will be missed and the risk of extended incapacity will be increased, leading to longer claims duration and increased workers' compensation premiums.

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DELAYS IN LODGING WORKERS' COMPENSATION CLAIMS

The SANO research found considerable delays between the date of the initial injury and date of lodgement of a claim with the employer—across the claims sample this delay averaged 38 days.

In some cases, this delay was because employees did not lodge a claim until it became apparent that their injuries were going to involve time off work, or extended periods of treatment or rehabilitation. In other cases, it was due to the stigma that injured workers felt about lodging a claim, or to the employee's belief that they could manage their injury without it impacting on their work.

These delays were more prevalent for injuries that were characterised by slow onset. These injuries had an average time to lodgement with the employer of 64 days, compared to an average of 35 days for injuries that were sustained suddenly. This highlights the need to provide employees with information about the nature of these conditions, reporting measures, contact procedures and the assistance that is available if symptoms develop over a period of time.

Delays were also found to occur following the receipt of the claim by the employer. For the body stressing sample, the average time taken from receipt of the claim by the employer to lodgement with Comcare was 12 days. However, in the more complex cases, the research found that it was taking employers longer to lodge a claim with Comcare. Cases that were not back at work by 12 weeks had the longest average time from receipt of the claim by the agency to its lodgement with Comcare of 17 days.

Delay in lodging a claim should not delay provision of appropriate treatment to the injured worker. Such a delay can signal to an employee that the agency does not support their claim and thereby increase the risk of higher rates of ill health and time off work, and present an obstacle to early recovery.

SANO's research identified the need for employers to review their arrangements for lodgement of workers compensation claims with Comcare. It also recommended that agencies benchmark their performance in terms of time between date of injury, date of lodgement of the claim by the employee, and date of lodgement of a claim by an employee and date of submission of that claim to Comcare by the employer.

IDENTIFYING AND MANAGING RISK FACTORS

International research has shown that psychosocial factors and other risk factors are far more important in predicting which employees, having been injured at work, will suffer delays or fail to recover or return to work following a workplace injury, than are the physical factors such as the nature of the injury[1,2].

These risk factors (sometimes called 'flags') include an individual's beliefs and perceptions—for example about pain and injury—and perceived features of the work or the social environment (such as unsupportive management, perceived time pressure or low job control). These risk factors, together with practises in medicine, employment and compensation systems, can lead employees injured at work to experience periods of incapacity that can be quire disproportionate to the nature of their injury.

SANOS' research confirmed these findings. Claims in the sample which had experienced more than 12 weeks of incapacity were found to have on average 5.8 identified risk factors, compared with 2.9 risk factors for claims of 4–12 weeks of incapacity, and 2.0 risk factors for claims of one to four weeks of incapacity. The most prevalent risk factors found were

non-evidence based medical treatments, delayed rehabilitation efforts and unsupportive line management.

Cases at risk of poor return to work outcomes can be identified early using the 'flags model' (Table 1). Identification and management of psychosocial risks (yellow flags) and other risks related to perceived or actual features of the workplace (blue and black flags) needs to become a priority. It is important that a sense of urgency is applied to the management of these factors within the first 12 weeks—preferably, return to work planning should address these factors by the six to eight week mark.

THE IMPORTANT ROLE OF WORKPLACE REHABILITATION PROVIDERS

Workplace Rehabilitation Providers (WRPs) have a key role in assisting employers to address the risks of poor rehabilitation and return to work outcomes.

The SANO research found there was a substantial understanding on the part of providers of the impact of psychosocial and other risk factors on return to work outcomes. However, there was little evidence of assessments and planning moving beyond a narrow biomedical model of injury management to address the range of non-medical factors. The research found that even when WRPs had identified the presence of risk factors, their reports did not systematically document identified key barriers to recovery and strategies to address them.

WRPs should be aware of the anticipated timeframes for recovery for body stressing injuries, and should create rehabilitation plans that reflect these timeframes and create an environment of proactive managing of barriers to successful recovery and return to work. For example, initial rehabilitation and return to work plans should be developed for a period of no more than eight weeks, with a clear expectation that the injured employee will be fit for full duties by no more than 12 weeks. Progress reports should use an exception reporting approach to alert stakeholders when an injured worker fails to make expected return to work progress.

Service agreements or contracts with WRPs should make it clear that assessments and rehabilitation planning should address all relevant risks to successful recovery and return to work. Such arrangements should require providers to complete documentation that summarises identified key barriers to recovery, and strategies to address such barriers for discussion with other key stakeholders.

1 Psychology, Personal Injury and Rehabilitation, A Report of a Working Party of the International Underwriting Association of London and the Association of British Insurers, 2004.

2 Guide to Assessing Psychosocial Yellow Flags in Acute Low Back Pain; Risk Factors for Long-Term Disability and Work Loss, Accident Compensation Commission, New Zealand, January 1997.

EVIDENCE BASED TREATMENT

When significant psychosocial and other risk factors are present or when incapacity has continued for more than 12 weeks, a different approach to the management of the injured employee is required.

This is because passive treatments aimed at alleviating the underlying injury are no longer likely to be of benefit. Return to work and treatment interventions that include a strong self-management approach and behavioural strategies[3] are more effective in reducing disability for cases at risk of ongoing pain and incapacity.

The SANO research found many examples of treatments, such as passive physiotherapy, extending long after the medical evidence would suggest that such treatments were beneficial. This may be partly due to the fact that delays in commencing rehabilitation activity result in treatment being provided as if the injury was recent—when it is actually being initiated beyond the normal recovery period. This finding also suggests a lack of understanding among key stakeholders, including agency case managers, claims managers, and treatment providers of the drivers and management of persisting pain.

WRPs can play an important role in assisting injured workers, case managers, treatment providers and others at the workplace to understand approaches to evidence-based treatment approaches. Case conferencing with treatment providers to assess treatment plans and goals, and to discuss appropriate progression of treatment and investigations in line with the principles of evidence-based treatment, can be very beneficial in ensuring timely and successful improvement towards recovery from injury and return to work.

3. Elements of a cognitive behavioural approach may include: problem solving to break the required goal into tasks with achievable steps, reinforcement (eg through positive feedback), identifying and challenging beliefs or perceptions that work against recovery, and offering new ways to manage problems (eg techniques to cope with pain).

PROACTIVE INJURY MANAGEMENT AND COORDINATION

Proactive management of injured workers and effective communication and coordination between line managers, case managers, claims managers, doctors, WRPs and injured workers is essential to achieve effective and safe return to work outcomes.

SANO's research found that many instances where large numbers of stakeholders were involved in claims management, case management, rehabilitation and treatment with inadequate information sharing and coordination of interventions.

Structured case conferencing of high risk cases is needed to promote collaborative problem solving in relation to identified issues. These conferences should include the case manager, claims manager and the WRP, and may also involve the treatment provider, line manager and injured worker as appropriate.

Case managers can be proactive in escalating issues to more senior management when local workplace factors constitute a barrier to return to work—for example, when relationships have broken down and the case manager is unable to facilitate return to work through the employee's direct line manager. Agency leaders can be instrumental in fostering a culture of support and early intervention within a workplace, and in providing direction and leadership in managing workplace barriers such as communication issues, relationship breakdowns and difficulties in identifying and providing appropriate suitable duties.

Comcare will continue to working actively to improve the communication between stakeholders, and to help coordinate claims and case management to address risk factors and facilitate early, safe and durable return to work.

TABLE 1

Indicators of poor outcomes or delayed recovery—the flags model

Red Flags **Medical**	Serious pathology/diagnosis
	Co-morbidity (i.e. co-existence of other diseases)
	Failure of treatment
Yellow Flags **Psychological**	Beliefs about pain & injury (e.g. that there is a major underlying illness/disease, that avoidance of activity will help recovery, that there is a need for passive physical treatments rather than active self-management)
	Psychological diseases (e.g. depression, anger, bereavement, frustration)
	Unhelpful coping strategies (e.g. fear of pain and aggravation, catastrophising, illness behaviour, overreaction to medical problems)
	Perceived inconsistencies and ambiguities in information about the injury and its implications
	Failure to answer patients' and families' worries about the nature of the injury and its implications
Blue Flags **Perceived features of work or the social environment**	High demand/low control
	Unsupportive management style
	Poor social support from colleagues
	Perceived time pressure
	Lack of job satisfaction
	Work is physically uncomfortable
Black Flags **Not matters of perception, affect all workers equally**	Employer's rehabilitation policy deters gradual reintegration or mobility
	Threats to financial security
	Litigation/disputation over liability or contribution
	Qualification criteria for compensation (e.g. where inactivity is a qualification criterion)
	Financial incentives
	Lack of contact with the workplace
	Duration of sickness absence
	Poor co-ordination between employers and those responsible for medical care

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