Evaluation of Vocational Rehabilitation under the IPRC Act 2001

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Executive summary

Background

The Accident Compensation Corporation of New Zealand commissioned a research study to explore the extent to which the goals and intent of the Injury Prevention, Rehabilitation, and Compensation Act 2001 ("the Act") are being met with regard to the provision of vocational rehabilitation. This research commenced January 2006 with the final report being submitted January 2007.

Six key questions were addressed in the research:

1) What are the specific indicators (criteria of success) for meeting the intent and goals of the Act across all processes and outcomes in vocational rehabilitation?
2) To what extent is current practice in assessment, rehabilitation processes and outcomes achieved, addressing the specific criteria identified by answering question 1?
3) What are the strengths and weaknesses in current approaches that are being used in relation to addressing the intent and goals of the Act?
4) How do the various stakeholders perceive their role and that of others in supporting vocational rehabilitation processes and outcomes as embodied in the Act?
5) What are the components of 'best practice' in vocational rehabilitation with specific reference to meeting the intent and goals of the Act?
6) What are the ramifications of these findings in relation to current practice and future developments of policy and practice in vocational rehabilitation?

The research process

There were five stages to data collection carried out between March and December 2006, all of which were approved by National Regional Ethics Committee and ACC's internal research management committee:

1) Development of a criteria checklist and Global Domain score regarding the key criteria reflecting the goals and intent of the Act (derived in consultation with ACC and other stakeholders).
2) Claimant survey regarding vocational rehabilitation received and their current health and occupational status.

3) Case note review of quality indicators reflecting the goals and intent of the Act.
4) A set of interviews with a subset of claimants.
5) Individual interviews or group discussions with stakeholders involved in the vocational rehabilitation process.

A random sample of 1184 claimants with claims throughout 2003-2004 in four strata (based upon length of compensation) were invited to participate (those with serious injury or sensitive claims were not included in this research). Overall response rate was 55% (n=646). Completed surveys were received from 581 people (49%) and case note reviews were carried out on 547 sets of records (46% of the total sample). Thirty claimants were interviewed in depth.

Over 80 stakeholders have been consulted, in group discussions or individual interviews from within ACC (corporate office and network) and outside ACC (general practitioners, health care professionals, vocational rehabilitation providers, employers and lawyers working with ACC claimants).

Results in context

The majority of claimants and stakeholders reported support for the unique opportunities for rehabilitation made possible within our no fault compensation system. However, as might be anticipated, a number of the findings are somewhat critical and recommendations for change are proposed for ACC's consideration. Importantly, such critique occurs in a context where nearly all stakeholders (including those internal to ACC) indicated:

a) prior recognition of barriers to achieving vocational rehabilitation in a way that reflects the key goals and intent of the Act.

b) aspects of service processes and structure impacting on quality and claimant outcomes that could and should be changed.

c) a recognition that despite the difficulties inherent in changing the culture of any system or organisation, particularly one as complex and large as ACC, steps to do this were required if the effectiveness and appropriateness of vocational rehabilitation were to be improved.

A number of the findings from this research are perhaps unsurprising given that we know the majority of people who are ACC claimants return to work (RTW) after

injury whilst a smaller proportion experience great difficulty, taking a protracted time to return or in fact losing their jobs. However, the report identifies some specific factors that appear to contribute to those difficulties and importantly, are amenable to change. By and large the recommendations therefore focus on these factors (in the main ACC structures and ACC or Provider processes) in an effort to point to ways that claimant participation in vocational rehabilitation can be enhanced and importantly, improved outcomes can be achieved.

The following pages of the Executive Summary highlight specific findings of interest and the key recommendations emerging from this research. A number of recommendations echo those made in an earlier report commissioned by ACC (titled Complex Assessment Project) submitted by members of this research team in 2006.[1] Recommendations and reference material from that report are included here (Appendix 10).

Whilst it is time consuming to read the full results in any report, we would of course, encourage it. Although an immense amount of data was collected, we have targeted the key aspects for statistical evaluation. Further, the qualitative interview extracts included (from both claimants and stakeholders) provide a degree of depth towards understanding both the difficulties experienced and the keenness of those working in the field to improve the vocational rehabilitation process and outcomes for ACC claimants.

Key findings

1. Approximately 70% of claimant records were assessed as requiring improvement in vocational rehabilitation in each of the 15 domains if the goals and intent of the Act are to be met. The domains are shown in Table 2 and include: claimant centeredness; communication; appropriateness of assessment and interventions; maintenance of current employment status.
2. Maori were significantly less likely to be assessed as having vocational rehabilitation that met the standard defined for meeting the goals and intent of the Act.

[1] Kayes, N. McPherson, K.M. Reid D. Complex Assessment Project. A Report commissioned by the Accident Compensation Corporation March 2006

3. Those with back and spinal injury were assessed as being the least likely to have vocational rehabilitation that met the standard defined for meeting the goals and intent of the Act.
4. Claimants who sustained their injury at work were assessed as significantly less likely to have had vocational rehabilitation that met the standard defined for meeting the goals and intent of the Act.
5. Claimants with multiple case managers (those with 3 or more in the first year) were assessed as being significantly less likely to have vocational rehabilitation that met the standard for meeting the goals and intent of the Act.
6. The degree to which the goals and intent of the Act were met (as measured in the Global Domains) was related to work status at the time of survey.
7. Provider assessments and interventions are of variable quality and appropriateness (indicated by data from claimant survey, case note review, expert review of IOA and IMA process, claimant and stakeholder interviews).
8. The role of case managers appeared focused predominately on compensation and claim management with rehabilitation frequently being secondary.
9. The nature and effect of Key Performance Indicators (KPIs) drive behaviour that is not always focused on rehabilitation and/or compromises claimant centred rehabilitation for RTW and independence
10. An explicit connection between the assessment processes, claimant needs and consequent actions was frequently difficult to determine.
11. Key tools for rehabilitation such as Individual Rehabilitation Plans (IRPs) rarely include claimant's own goals.
12. A lack of early intervention with nearly 50% of those off work for three to twelve weeks reporting no information about return to work being provided.
13. A lack of team work is evident. This appears partly associated with workload issues but also a lack of a shared perspective on rehabilitation (see below).
14. A fundamental barrier to working with a number of claimants, and achieving good outcomes for those with complex conditions and circumstances, is that relationship building appears overlooked as a key role for case managers.

15. Current vocational rehabilitation appears to focus more on standard programmes of intervention, many of which are lacking evidence of effectiveness (such as activity based programmes), rather than being tailored to the individual claimant requirements.

16. All stakeholders agreed that they had key roles in supporting vocational rehabilitation. However – significant problems in fulfilling that role were highlighted including:

    - A lack of communication between stakeholders
    - Difficulty in allocating resources/time needed for appropriate involvement in vocational rehabilitation
    - Lack of early involvement of the appropriate parties (including the GP, employer and other stakeholders).

Key recommendations

1. Improved evidence about outcome is required:

1.1 to underpin and improve risk assessment and prioritisation of services.

1.2 to determine the efficacy of specific vocational rehabilitation interventions to ensure appropriate allocation of funding and resources

1.3 evaluating the cost effectiveness of what appear high 'up front' cost rehabilitation strategies such as education and retraining in contributing to better long term outcomes (improved return to work and independence and therefore reduced long term costs for ACC and other government services).

2. Revised structures (staffing, documentation for case management, documentation for audit and review) are required:

2.1 to present a higher profile on 'rehabilitation'[2] in ACC's image and promotional material. It is noteworthy that whilst the word and its meaning features greatly in the legislation, it is absent from much of the promotional material of ACC, including the logo:

[2] It has been shown that many people take *recovery* to mean *back to the same state as prior to injury*. However *rehabilitation* includes a focus on living with altered abilities and ongoing consequences of a condition. This semantic difference is potentially very significant.

2.2 to provide and support a model of case management focused on rehabilitation (reducing work disability and enhancing work participation) as well as claim management. This is particularly important for those at risk of long term work disability.

2.3 by restructuring documentation such as Individual Rehabilitation Plans to facilitate whole of person assessment and involvement of the individual in goal setting.

2.4 to underpin contracting with providers of both assessment and interventions to allow whole of person consideration - of paramount importance for those at high risk of inappropriate work disability.

2.5 to facilitate standardisation of high quality service that is never-the-less individualised.

2.6 that facilitate and support processes focused on rehabilitation early in a claimant's association with ACC (see below).

3. A review of core processes is proposed:

3.1 to ensure they relate to the overall purpose and intent of the Act and are focused on improving outcome rather than being an end in themselves. Such processes include but are not limited to communication with claimants, timeframes for completion of occupational assessments and, timeframes and approach to Individual Rehabilitation Plans (see 2.3).

3.2 to maximise claimant involvement and engagement in the process of return to work and vocational rehabilitation. An urgent review of approaches to expectation setting, communication and power sharing are required both within ACC and for early contact providers.

3.3 to facilitate the engagement of all stakeholders in the most appropriate manner depending on each claimant and their circumstances. Whilst a number of claimants may not return to their pre-injury work and some may not return to work at all, early and appropriate involvement of all stakeholders has potential to minimise this risk.

February 19th 2007

Background to the research

Vocational Rehabilitation is a core aspect of enhancing return to work (RTW) and a legislative entitlement for New Zealanders within the Injury Prevention, Rehabilitation and Compensation Act.

For the individual, successful vocational rehabilitation potentially leads to enhanced financial security and other directly or indirectly associated benefits such as health and quality of life gains, re-establishing one's sense of self if work has previously been important, maintaining or achieving a desired place in society, and the ability to perform other important life roles within the family and community (Szymanski et al 2003)[3]. RTW is also key to a healthy functioning society as employees returning to the workforce contribute to the cost-benefit of vocational rehabilitation as society realises gains in its productivity and resource base (Fulton-Kehoe et al 2000)[4].

Promoting successful RTW after injury, where possible and appropriate, is therefore a crucial aspect of ACC's adherence to the Act. Whilst many people return to work unassisted after injury, approximately 105,000 ACC claimants per year are assessed as requiring social and vocational rehabilitation. Whilst this number appears relatively small in comparison with the total number of ACC claims (7%), the legislative mandate, and potential gains for individuals and society, means it is crucial to determine whether assessment processes and associated vocational rehabilitation services are meeting the intent and goals of the Act.

Rehabilitation and legislation

In order to provide further context for the research, a brief summary of relevant aspects of the legislation is provided below.

Rehabilitation is defined under the IPRCA 2001 at Sec 3 (c). The purpose of the Act includes under Sec 3 (c) "ensuring that, where injuries occur, the Corporation's primary focus should be on rehabilitation with the goal of achieving the appropriate quality of life through the provision of entitlements that restores to the maximum practicable extent a claimant's health, independence and participation."

[3] Szymanski, E., G. Parker, C. Ryan, et al., Work and Disability: Basic Constructs., in Work and Disability, E. Szymanski and R. Parker, Editors. 2003, PRO-Ed.: Austin, TX. p. 1-26.

[4] Fulton-Kehoe, D., G. Franklin, M. Weaver, et al., Years of Productivity Lost among Injured Workers in Washington State: Modeling Disability Burden in Workers' Compensation. Am J Ind Med, 2000. 37(6): p. 656-62.

Under Sec 6(1), practicable in relation to rehabilitation means practicable is after considering and balancing the following:

(a) the nature and consequences of the injury;
(b) the achievement of rehabilitation outcomes;
(c) costs;
(d) cost effectiveness;
(e) the availability of other forms of rehabilitation;
(f) other relevant factors.")

Clarification of "rehabilitation" is further provided at Sec 6(1):

*"Rehabilitation—

(a) means a process of active change and support with the goal of restoring, to the extent provided under section 70, a claimant's health, independence, and participation; and

(b) comprises treatment, social rehabilitation, and vocational rehabilitation."

Section 70 discusses the claimant's and corporation's obligations in relation to rehabilitation stating;

A person who has suffered personal injury for which he or she has cover –

(a) is entitled to be provided by the corporation with rehabilitation, to the extent provided by this Act, to assist in restoring the claimant's health, independence and participation to the maximum extent practicable; but

(b) is responsible for his or her own rehabilitation to the extent practicable having regard to the consequences of his or her personal injury)

'Treatment' is defined in section 6 as (a) physical rehabilitation, (b) cognitive rehabilitation, or (c) an examination for the purpose of providing a certificate including the provision of the certificate. It is also further defined in s 33 but this is specifically related to 'treatment injury' and the definitions in this section do not override those in s 6.

Although vocational rehabilitation itself is not defined under the interpretation portion at Sec 6, according to Sec 80 (1) the "purpose of vocational rehabilitation is to help a claimant to, as appropriate,--

(a) maintain employment; or
(b) obtain employment; or
(c) regain or acquire vocational independence…

Vocational rehabilitation includes provision of activities for the purpose of maintaining or obtaining employment that is:-

(a) suitable for the claimant; and

(b) Appropriate for the claimant's levels of training and experience.

(s 80 (2))

S 80 (2) also contains the provision that it should not limit subsection (1).

Also, when providing vocational rehabilitation the corporation *must* consider cost effectiveness, whether the voc rehab is likely to achieve its purpose, and whether its appropriate in the circumstances (s 87 (1) (a,b,c)). Finally, when determining a claimant's voc rehab needs beyond maintaining work, the assessment must consist of an IOA and IMA (s 89).

Social rehabilitation is considered separately within the legislation however, it clearly has relevance and connection to vocational rehabilitation. According to Sec 79, "The purpose of social rehabilitation is to assist in restoring a claimant's independence to the maximum extent practicable. Also, Sec 84 addresses assessment and reassessment of need for social rehabilitation. Sec 84(4): "The matters to be taken into account in an assessment or reassessment include—…

(g) any social rehabilitation (not provided as vocational rehabilitation) that may reasonably be provided to enable a claimant who is entitled to vocational rehabilitation to participate in employment".

S 81 states the Corporation's liability to provide key aspects of social rehabilitation;

In this section, key aspect of social rehabilitation means any of the following:…

(h) training for independence

'Independence' is defined in s 12 of the Act as:

Independence includes the capacity to function in the following areas:

(a) communication:

(b) domestic activities:

(c) educational participation:

(e) financial management:

(f) health care:

(g) hygiene care:

(h) mobility:

(i) motivation:

(j) safety management:

(k) sexuality

(l) cognitive tasks of daily living, such as orientation, planning and task completion:

(m) use of transport

The Act's intent regarding rehabilitation in Sec 6(1) (a) and (b) are above (pg 2 *)

Section 117 allows the Corporation to suspend, cancel or decline entitlements and states:

(1) The Corporation may suspend or cancel an entitlement if it is not satisfied, on the basis of the information in its possession, that a claimant is entitled to continue to receive the entitlement…

(3) The Corporation may decline to provide any entitlement for as long as the claimant unreasonably refuses or unreasonably fails to –

(a) comply with any requirement of this Act relating to the claimant's claim; or

(b) undergo medical or surgical treatment for his or her personal injury, being treatment that the claimant is entitled to receive;

or

(c) agree to, or comply to, an individual rehabilitation plan.

This evaluation project was commissioned by ACC as a step towards improving vocational rehabilitation by identifying the strengths and weaknesses of current approaches in relation to the goals and intent of the IPRC Act 2001. The study aimed to answer the following six key questions:

1) What are the specific indicators (criteria of success) for meeting the intent and goals of the Act across all processes and outcomes in vocational rehabilitation?
2) To what extent is current practice in assessment, rehabilitation processes and outcomes achieved, addressing the specific criteria identified by answering question 1?
3) What are the strengths and weaknesses in current approaches that are being used in relation to addressing the intent and goals of the Act?
4) How do the various stakeholders perceive their role and that of others in supporting vocational rehabilitation processes and outcomes as embodied in the Act?
5) What are the components of 'best practice' in vocational rehabilitation with specific reference to meeting the intent and goals of the Act?
6) What are the ramifications of these findings in relation to current practice and future developments of policy and practice in vocational rehabilitation?

The report focuses particularly on these issues with related publications exploring some aspects in more depth to be developed over the first six months of 2007. Copies of publications will be provided to ACC prior to publication.

For ease of reading the report, discussion is provided alongside findings in the Results section rather than in a separate section.

This is followed by a section on Recommendations and Conclusions.

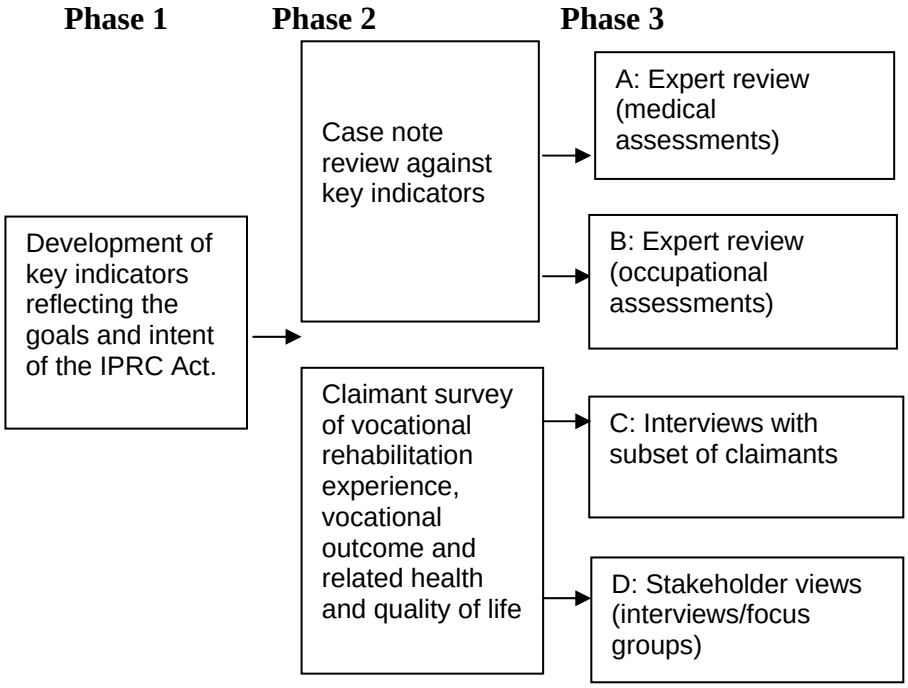
Finally a set of appendices are included that provide copies of documentation used and other related materials.

Methods

Design

Both qualitative and quantitative methods were used to answer the questions noted above.

Figure 1 Overall study design



Development of key indicators

The research team derived a set of 46 criteria items (see Appendix 1) in conjunction with: key informants in ACC; reference to the IPRC Act 2001; and documentation currently used by ACC. In the initial proposal we suggested using a Delphi method for defining criteria or key indicators. The Delphi method[5] is a formalised approach to the development of consensus where 'experts' participate in defining and analysing complex problems or issues where information is fragmentary or difficult to define. We believed that it would have had particularly useful application for consolidating definitions of the key and measurable indicators of vocational rehabilitation performance in relation to the Act and for seeking to generate a shared understanding of those definitions. However, as the advisory group preferred this process was not

[5] Hearnshaw H, Harker R, Cheater F, Baker R , Grimshaw G. A study of the methods used to select review criteria for clinical audit. Health Technol Asses 2002; 6(1)

used, a more limited approach to consensus regarding the key criteria was utilised as noted above.

In addition, fifteen global or summary domains reflecting overall performance in relation to the key goals and intent of the Act were derived through a similar process of consultation and refinement (see Table 2 below).

Table 2 Global Domains Assessed

1	Claimant centeredness	9	Implementation of plan / decision making
2	Expectation setting	10	Evaluation and monitoring
3	Claimant accountability	11	Overall timeliness
4	ACC communication with the claimant	12	Overall appropriateness
5	Team makeup	13	ACC facilitation of maintaining work role
6	Information gathering	14	ACC facilitation of obtaining work role
7	Whole team communication	15	ACC facilitation of regaining work capacity
8	Relationship building and maintenance		

Each case record (case file + Pathway where this was available) was assigned a score according to the level of performance with definitions for meeting the standard specified in Appendix 2. Each record was then assessed as:

1= exceeding the expected standard

2 =meeting the expected standard – a definition provided for each item

3 =failing to meet the expected standard – a definition provided for each item

4 =falling far below the expected standard (ie not meeting level 3)

The reliability the Global Domain scoring system was evaluated in the early stages of case note review process leading to revisions and clarifications to the definitions (final version noted above) and a standard operating procedure to be followed in the case note evaluation process to reduce subjectivity in scoring. This process lead to acceptable levels of inter-rater reliability (see Appendix 4) and its use is described below in the description of the review. Specific criteria and their relationship to the global indicators are highlighted in Appendix 3.

Claimant survey and case note review

Ethical approval was granted by the National Regional Ethics Committee and ACC's internal committee. A freephone number was provided for claimant access throughout the duration of the study.

Sample: A potential sample pool of 1600 was randomly selected from within ACC's register of claimants in four strata according to the duration of weekly compensation: 3 to 12 weeks, 13 to 26 weeks, 27 to 52 weeks and over 52 weeks. The recruitment strategy was complex in order to try and maximise response rates given previous poor recruitment experienced in research commissioned by ACC. The process for recruitment included up to five contacts with each claimant and is outlined in Appendix 5. A subcontracted agency was used to make contact with potential participants in order to meet ethical requirements.

Measures – Case Note Review: A set of core indicators of meeting the goals and intent of the Act in relation to vocational rehabilitation and 15 Global Domain indicators were derived as described above (see Appendix 1 and 2).

Measures – Claimant Survey: Few standardised measures of vocational rehabilitation exist and further, those that do explore only a limited range of variables such as 'satisfaction' or crude outcomes such as hours of work. As a result, no single measure was directly applicable in this research where the intention was to explore vocational outcome, the experience of rehabilitation in domains central to the Act, and also health / quality of life outcomes. Three tools were therefore used to collect data across these domains:

1) The Short Form 36 questionnaire Version 2 (SF-36)[6]
2) The Personal Capacities Questionnaire (PCQ), a self report version of the Functional Capacities Index[7] highlighting areas of difficulty that could impact on ability to work.
3) A specifically derived Claimant Experience of Vocational Rehabilitation Questionnaire to capture domains considered specifically related to the aims and intent of the Act.

[6] Brazier, L., et al., Validating the SF-36 health survey questionnaire: new outcome measure for primary care. British Medical Journal, 1992. 305: p. 160-164.

[7] Bolton, B. (2001). Handbook on measurement and evaluation in rehabilitation. Gaithersburg, MD; Aspen Publication

Both the SF-36 and PCQ have established psychometric properties. However, as a non-standardised measure of vocational rehabilitation experience was required, a number of steps in development were included eg building the questionnaire from initial discussions within the research team and stakeholders including employees who had been off work due to injury and piloting the questionnaire for utility and acceptability. Minor changes were made to the questionnaire on the basis of feedback and a copy of the final questionnaire is provided in Appendix 6. It covers a number of the same global criteria examined in the case note review but clearly target the claimant perspective rather than evidence within the case notes.

Procedure: Following the procedure outlined in Appendix 5, information was provided to potential participants and consent gained for survey and/or case note review data. Initial consent and involvement was sought by ACC's subcontractor. A number of potential participants returned only questionnaires (no consent form indicating willingness for the other aspect of data collection). Whilst completion of a questionnaire implies consent for the use of that data, participants needed to provide specific consent for case note review. An attempt was then made to obtain consent for case note review from those who may only have returned questionnaires. A number of participants agreed to take part but only if the research team carried out the questionnaire by phone in the evenings or weekends and this was integrated into the study operations.

The case note review process involved researchers obtaining a copy of the ACC file for all claimants who had consented to take part. In discussion, it was realised that access to the electronic record for participants was also required. Three members of the research team (CC, KJ and NM) were based at branch offices in order to access the Pathway record during the case note review process.

Expert medical and occupational assessment review

A subset of 30 records were selected for expert review of the occupational and medical assessment process with a particular focus on those aspects related to vocational rehabilitation. Case notes were selected by the researchers on the basis of reflecting variable performance on the Global Domain scoring such that we intended to find some examples of 'best practice' as well as to highlight difficulties. Expert reviewers had significant experience and expertise in both carrying out the assessments and also auditing of other provider assessments.

Claimant in depth interview

A subset of 30 participants who had indicated that they would agree to be interviewed were contacted and invited to take part in a tape recorded interview of 60 to 90 minutes duration to discuss in more depth their experience of vocational rehabilitation. (It is notable that a number of people who refused to take part in survey or case note review would have agreed to take part in interviews which may be important for future research methods in this area).

Interview participants were selected by the researchers in an effort to recruit claimants with varying experience based upon their questionnaire data and the Global Domain scoring and to reflect different demographic details such as gender, ethnicity, age, type of work, type of injury. Whilst some of these cases may have also had expert medical or occupational case note review, this was not necessarily the case as we wished to explore different aspects of vocational rehabilitation.

Interviews were carried out face to face or by telephone according to what suited the participant. All interviews were carried out by experienced researchers and were taped and transcribed verbatim.

Stakeholder views – interviews and focus group discussions

Gaining input from the various stakeholders involved in vocational rehabilitation was considered vital for three reasons a) to determine what stakeholders felt their role in vocational rehabilitation was or could be b) to determine how well stakeholders felt the current approach addressed the goals and intent of the Act and c) to provide a context for the interpretation of research as it would allow some discussion and exploration of preliminary and emerging findings.

Again, interviews and group discussions were carried out face to face or by telephone according to what suited the participant. All interviews were carried out by experienced researchers and were taped and transcribed verbatim.

Data management

All paper copy data was stored in locked filing cabinets with clear security pathways to prevent unauthorised access. All electronic data was stored in files on a secure network with password access only for authorised staff. An outline of security procedures to ensure confidentiality of claimants is provided in Appendix 7.

Claimant demographic details, questionnaire and case-note review data were managed in Microsoft Access 2002 (SP3)[8]. All datasets were linked by a unique record number. Any identifying claimant details such as name, address and birth date were kept in separate locked storage so that individual claimants could not be identified from the database. In order to confirm data entry accuracy, audit was performed throughout the project with: dual data entry of questionnaire data; 10% of case note criteria data entry double entered; additional audits of a small set of records.

Interviews were transcribed verbatim with all names and specific locations substituted for proxy identifiers, again to preserve the anonymity of participants.

Analysis

Quantitative Analysis: Descriptive analysis was used to explore frequencies and distribution of specific quantitative data for the total population and also according to the four strata (based upon the number of weeks compensation).

Inferential statistics, univariate and multivariate where appropriate were used to explore specific hypotheses associated with the study questions.

All statistical analysis was performed using Stata Version 8[9] or SPSS Version 14[10].

Qualitative Analysis: Non-numeric data from questionnaires and from interviews was analysed for consistent and/or important themes both with regard to a) problems and/or barriers to vocational rehabilitation in accord with the IPRC 2001 Act and b) possible ways of addressing these barriers. Data was analysed manually by reading and coding of manuscripts and augmented by the use of specialist software QSR XSight 2[11].

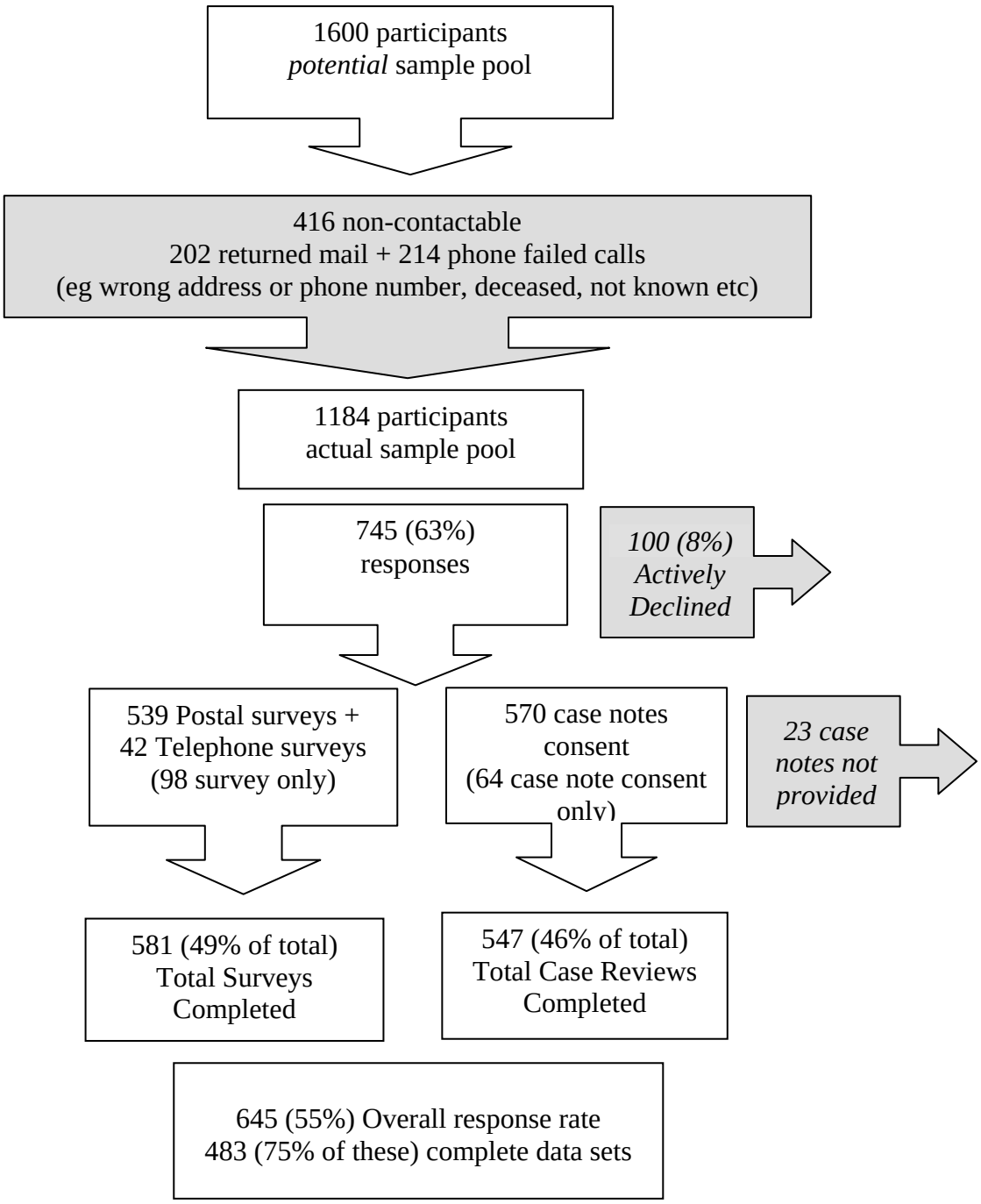
[8] Microsoft Access 2002
[9] http://www.stata.com/products/
[10] SPSS14.0.0 (5 Sep 2005)
[11] QSR XSight Version 2.0/73.0SP1 2006 (Patent Pending)

Results

Claimant participant features and demographics

Following the recruitment procedure outlined in earlier and in Appendix 5, an overall response rate of 55% (n= 646) to either case note review and/or survey was achieved. Completed surveys were received from 581 people (49%) and case note reviews were carried out on 547 sets of records (46% of the total sample) (see Figure 2 below).

Figure 2Response to recruitment



Full demographic information for individual claimants is only available for those who gave consent to case note review (n=547) and this is comprehensively evaluated in the case note review section of findings. It is important to note that overall, there appears bias in the sample recruited compared to the whole potential sample group (including responders, non responders and those who were not contactable).

Of particular note, a number of ethnic groups, particularly Maori, were under-represented as noted below.

Table 3 Ethnicity for responders versus total sample pool

Ethnicity Categories	Responders (n=547)	Total sample pool (1588)
1 - NZ Maori	6.76%	12.78%
2 - NZ European	80.99%	71.85%
3 - Pacific	1.10%	3.78%
4 - Asian	1.46%	2.58%
5 - Other	3.47%	3.34%
6 - No data	6.22%	5.67%

In addition, responders tended to be older and proportionally more women responded than men.

Table 4 Gender and age of responders versus potential sample pool

	Responders (n=547)	Total sample pool (1588)
Gender	68% male	72% male
Mean age at time of report	48.53 years (SD 13.98)	44.5 years (SD 14.28)

Injury distribution was similar across the two samples. Please note, the percentage for the total sample pool does not add to 100 due to missing data in the supplied ACC data file.

Table 5 Distribution of injury type – responders versus potential sample pool

Injury site categories	Responders (n=547)	Total sample pool (1588)
1 - Back/Spine	22.49%	22.36%
2 - Lower limb	36.38%	31.11%
3 - Upper limb	34.00%	32.18%
4 - Head	4.57%	4.41%
5 - Abdomen/Pelvis, Chest	2.56%	3.21%

Claimant survey – questionnaire data

Claimant Experience of Vocational Rehabilitation questionnaire

Data is largely presented in a descriptive manner (frequencies) given the retrospective nature of this questionnaire and data quality (not a standardised measure).

506 (87%) of claimants reported returning to work following their injury and 471 (81%) were working at the time of the survey. 260 (45%) were injured at work.

Perceived difficulties in returning to work:

Difficulties in returning to work were experienced by 250 (43%) of claimants and 304 (52%) stated they had difficulties coping when they actually did return. 36% (209) stated that they felt they had tried to go back to work too soon and 63% (365) considered that the injury that took them off work still continued to cause them difficulties.

Perception of the Vocational Rehabilitation Process

The figures below summarise the responses for claimants in each strata who answered YES to the following questions.

Table 6 Claimants perceptions of vocational rehabilitation

Numbers refer to those answering YES	Total population N (%)	3 to 12 weeks	13 to 26 weeks	27 to 52 weeks	over 52 weeks
Total number per strata	504	104	125	136	139
Was your return to work timely? (Q35)	264 (52%)	66 (64%)	71 (57%)	81 (60%)	46 (33%)
Did the help ACC organised regarding your work seem appropriate for you? (Q37)	272 (54%)	59 (57%)	66 (53%)	82 (60%)	65 (47%)
Did you get the help you needed at the right time? (Q36)	292 (58%)	61 (59%)	79 (63%)	89 (65%)	63 (45%)
Good or excellent support from ACC (Q28)	308 (61%)	49 (47%)	81 (65%)	98 (72%)	80 (58%)
Good or excellent support from Health professionals (Q27)	382 (76%)	70 (67%)	98 (78%)	112 (82%)	102 (73%)
Good or excellent support employer (Q26)	245 (49%)	52 (50%)	60 (48%)	80 (59%)	53 (38%)
Good or excellent support co-worker (Q25)	265 (53%)	52 (50%)	71 (57%)	81 (60%)	61 (44%)
Good or excellent support family (Q29)	435 (86%)	89 (86%)	110 (88%)	122 (88%)	114 (82%)

Overall claimants reported that they had good or excellent support from health professionals and family. However, those who were on claim for 52 weeks or longer

perhaps unsurprisingly report less support from their employer (38%) and co-workers (44%). Interestingly those who reported the most support from ACC were those who were on claim from 27 to 52 weeks.

Claimant involvement / whole person context

The table below highlights the proportion of claimants who considered their own ideas were taken into account by ACC and related questions.

Table 7 Involvement in plans and goals / whole person context (total population)

Total n= 504	Yes or Very much	In part or A little	No or Not at all	Not applicable	No data
Claimant goals taken into account by ACC (Q30)	329 (65%)	NA	131 (26%)	14 (3%)	30 (6%)
Claimant feeling involved in setting goals (Q31)	320 (64%)	106 (21%)	51(10%)	0 (0%)	27 (5%)
Other roles considered (Q33)	163 (32%)	102 (20%)	200 (40%)	17 (3%)	22 (5%)
Other activities considered (Q34)	170 (34%)	101 (20%)	198 (39%)	14 (3%)	21 (4%)
Family/whanau involved appropriately (Q32)	309 (61%)	0 (0%)	161 (32%)	12 (2%)	22 (5%)

Interestingly, the majority of claimants felt that their goals were taken into account (65%) and that they were involved in the goal setting process (64%). However, only one third felt that the full context of their life roles and activities were considered. We then explored the perceptions of claimants who felt they were not involved across the different strata (see the table below).

Table 8 Whole of person consideration according to duration of compensation

N % Answering	Total population N (%)	3 to 12 weeks	13 to 26 weeks	27 to 52 weeks	over 52 weeks
Total number per strata	504	104	125	136	139
Claimant goals NOT taken into account by ACC (Q30)	131(26%)	33 (32%)	28 (22%)	28 (21%)	42 (30%)
Claimant NOT feeling involved in setting goals (Q31)	51(10%)	14 (14%)	10 (8%)	10 (7%)	17 (12%)
Other roles NOT considered (Q33)	200 (40%)	56 (54%)	40 (32%)	41 (30%)	63 (45%)
Other activities NOT considered (Q34)	198 (39%)	51 (49%)	48 (38%)	37 (27%)	62 (45%)
Family/whanau NOT involved appropriately (Q32)	161(32%)	34 (33%)	45 (36%)	29 (21%)	53 (38%)

It certainly appears as if the majority of claimants across the strata perceived that they were involved in goal setting. This seems slightly at odds with the finding that a significant number of claimants (just over a quarter) felt that their own goals were not taken into account by ACC. This may suggest that claimant involvement in goals is:

a) often associated with the goals ACC sets for them or

b) frequently in relation to involvement with health professionals.

Early support/intervention

Many claimants, particularly in the strata beyond 13 weeks, recorded little information about RTW being provided in the early weeks after injury.

Table 9 Time to information about RTW

	Total population N (%)	3 to 12 weeks	13 to 26 weeks	27 to 52 weeks	over 52 weeks
Within 2 weeks	156 (30%)	46 (30%)	46 (29%)	37 (24%)	27 (17%)
Within 6 weeks	136 (27%)	16 (12%)	37 (27%)	45 (33%)	38 (28%)
Within 3 months	52 (10%)	4 (8%)	8 (15%)	17 (33%)	23 (44%)
Over 3 months	73 (15%)	2 (3%)	11 (15%)	22 (30%)	38 (52%)
Never	63 (13%)	30 (48%)	16 (25%)	9 (14%)	8 (13%)

Notes for interpretation of claimant questionnaire:

Given that this data was not collected around 18 months to two years since claim registration, some recall bias may be influencing responses.

SF36 and Personal Capacities Questionnaire (PCQ) data

For the SF 36 physical and mental health global scores, complete information was available from 559 participants, while for the PCQ questionnaire, complete information was available from 574 participants. The table below summarises information on the location and spread of these distributions.

Table 10 Location and spread statistics for the distributions of SF36 and PCQ.

	n	median	IQR (25^{th}, 75^{th})	Range (min, max)
SF36				
Physical component score	559	45.9	(37.6, 53.8)	(8.8, 68.7)
Mental component score	559	53.3	(44.1, 58.4)	(7.8, 71.2)
Personal Capacities Questionnaire (PCQ)	574	7	(2, 15)	(0, 153)

The mean scores on the SF-36 are shown below for the sample population (n=559) as well as for the New Zealand population from Scott et al 1999[12].

Table 11 SF36 for study sample compared with the New Zealand Population

	n	mean	S.E.	T-test P-value
Physical Component Summary score				P<0.001
ACC population	559	45.0	0.45	
NZ normative data	7445	50.1	0.2	
Mental Component Summary score				P=0.99
ACC population	559	50	0.48	
NZ normative data	7445	50.0	0.2	

A Student's t-test indicates a significant difference in mean physical component summary scores but no difference in mean mental component summary scores. Please note that although SF36 Version 2 was used in the ACC study and Version 1 in the normative data, scoring is the same.

We also explored whether there was any difference in the health state of those who completed the questionnaire and consented to case note review compared with those who did not.

[12] Scott, K.M., et al., SF-36 health survey reliability, validity and norms for New Zealand. Australian & New Zealand Journal of Public Health, 1999. 23(4): p. 401-406.

Table 12 SF36 Scores for study sample who consented to case note review compared with those who did not.

	n	mean	(SD)	T-test P-value
Physical Component Summary score				0.01
Case note review undertaken	468	45.5	10.4	
No case note review	91	42.5	11.5	
Mental Component Summary score				0.11*
Case note review undertaken	468	50.4	10.9	
No case note review	91	48.0	13.4	

**As the variance between groups were significantly different (Folded F-test P=0.001), Satterthwaite's correction was applied. If this difference between variances was ignored, there was still no significant difference between groups (P=0.07).*

PCQ data would suggest that four domains contribute the most (although all domains were observed to contribute to the overall PCQ score, as one would expect) in the following rank order:

- Q16 'Stability of condition'
- Q13 'Ability to do heavy work'
- Q14 'Endurance and availability for work'
- Q15 'Absence from work'.

Case note review data

Description of participants

Overall total case reviews were completed for 547 participants. Of these, 119 (21.8%) had their case active for 3-12 weeks, 138 (25.2%) were active for 13-26 weeks, 146 (26.7%) were active for 27-52 weeks, and 144 (26.3%) participants had their case active for greater than 52 weeks. These observed percentages are similar to the expected percentages of 25% per stratum, as anticipated by the design of the study.

The median age of the sample was 48.9 years, with range 17.3 years to 85.9 years, and interquartile range (IQR) of 38.5 years to 59.8 years. The median number of prior claims was 8, with range 0 to 82 (IQR: 4, 13) and the median number of case managers within the first year was 2, with range 0 to 7 (IQR: 1, 3).

The socio-demographics and relevant injury characteristics of the participants appears in Table 1 for the entire sample, and partitioned by the weeks case active strata. Continuous or skewed discrete variables were categorised into approximate quartiles, where possible, (such as age, and number of prior claims) or were collapsed into contextually meaningful categories (such as number of case managers within the first year).

Table 13 Socio-demographics and relevant injury characteristics of the participants within the entire sample, with the distributions within each stratum.

	Strata (weeks compensation)										
	Overall		3-12		13-26		27-52		>52		
Claimant Characteristic	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	P*
Gender											0.56
Female	173	(32)	40	(34)	48	(35)	40	(27)	45	(31)	
Male	374	(68)	79	(66)	90	(65)	106	(73)	99	(69)	
Age (years)											0.08
<40	153	(28)	42	(35)	34	(25)	39	(27)	38	(26)	
40-49	137	(25)	31	(26)	36	(26)	31	(21)	39	(27)	
50-59	125	(23)	25	(21)	28	(20)	31	(21)	41	(28)	
≥ 60	132	(24)	21	(18)	40	(29)	45	(31)	26	(18)	
Ethnicity[a]											0.57
Maori	37	(7)	5	(5)	8	(6)	13	(9)	11	(8)	
Pacific	6	(1)	1	(1)	3	(2)	2	(1)	0	(0)	
Asian	4	(1)	1	(1)	0	(0)	2	(1)	1	(1)	
European/other	467	(91)	103	(94)	118	(91)	121	(88)	125	(91)	

	Strata (weeks compensation)										
	Overall		3-12		13-26		27-52		>52		
Claimant Characteristic	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	P*
Injury site category											0.001
Back/Spine	123	(22)	19	(16)	30	(22)	30	(21)	44	(31)	
Lower limb	199	(36)	54	(45)	60	(43)	48	(33)	37	(26)	
Upper limb	186	(34)	40	(34)	42	(30)	58	(40)	46	(32)	
Head	25	(5)	1	(1)	5	(4)	6	(4)	13	(9)	
Abdomen/ Pelvis/Chest	14	(3)	5	(4)	1	(1)	4	(3)	4	(3)	
Number of prior claims[b]											0.01
0-4	136	(26)	36	(32)	41	(32)	33	(24)	26	(19)	
5-7	117	(23)	24	(21)	26	(20)	37	(26)	30	(22)	
8-12	130	(25)	30	(27)	37	(29)	35	(25)	28	(21)	
≥ 13	133	(26)	23	(20)	23	(18)	35	(25)	52	(38)	
Work related injury											0.02
No	327	(60)	78	(66)	91	(66)	73	(50)	85	(59)	
Yes	220	(40)	41	(34)	47	(34)	73	(50)	59	(41)	
Number of case managers within the first year[c]											<0.001
0	12	(2)	4	(4)	5	(4)	3	(2)	0	(0)	
1	223	(42)	65	(59)	59	(44)	51	(36)	48	(34)	
2	154	(29)	26	(23)	37	(27)	42	(30)	49	(35)	
≥ 3	141	(27)	16	(14)	34	(25)	46	(32)	45	(32)	

*P-values calculated using Fisher's exact test.
[a]33 (6.0%) participants had observations missing.
[b]31 (5.7%) participants had observations missing.
[c]17 (3.1%) participants had observations missing.

Table 1 reveals that there was no significant difference in participants' gender, age or ethnicity between the strata. However, significant differences existed for all other characteristics between the strata.

Quality of the rehabilitation journey in relation to the goals and intent of the Act (Global Domain Data)

Given the number of individual items involved in the case note review, the analysis here focuses predominately on the global domains summarising the overall quality of rehabilitation. A summary of some of the key individual criteria items of interest is provided in Appendix 3 and more data is available on request.

The table below provides the percentage distributions of case review ratings for each of the 15 variable components encapsulating the criteria for meeting the aim and intent of the Act (See Appendix 2 for definition of these global domains) for the n=547 participants. From these data, it can be seen that for most of the variable components (apart from claimant accountability, ACC facilitation of *obtaining* work

role, and ACC facilitation of *regaining* work capacity) the majority of records were assessed as requiring "Some improvement". That is to say, they did not meet the defined standard of expectation shown in Appendix 2.

Table 14 Distribution of case review ratings for each of the 15 Global Domains defined as making the claimant's Vocation Rehabilitation Journey.

n=547 participants	Exceeds expectation	Meets expectation	Some improvement required	Significant improvement required	Not applicable
	%	%	%	%	%
1. Claimant centeredness	1.3	24.5	70.9	3.3	-
2. Expectation setting	0.0	33.3	64.9	1.8	-
3. Claimant accountability	0.4	57.8	38.8	3.1	-
4. ACC communication with the claimant	1.3	26.3	71.3	1.1	-
5. Team makeup	0.6	33.1	63.8	2.6	-
6. Information gathering	0.4	27.8	67.1	4.8	-
7. Whole team communication	0.0	19.0	77.8	3.1	-
8. Relationship building and maintenance	0.9	25.4	70.7	2.9	-
9. Implementation of plan/decision making	0.6	26.3	67.8	5.3	-
10. Evaluation and monitoring	0.4	24.5	71.5	3.7	-
11. Overall timeliness	1.1	27.6	67.5	3.8	-
12. Overall appropriateness	0.6	26.7	69.7	3.1	-
13. ACC facilitation of *maintaining* work role	0.6	25.6	66.7	2.4	4.8
14. ACC facilitation of *obtaining* work role	0.0	3.8	11.3	3.1	81.7
15. ACC facilitation of *regaining* work capacity	0.0	1.3	6.0	1.1	91.6

NB: Not applicable scores are for those who did not enter that phase of vocational rehabilitation

Dichotomised frequencies

In order to investigate predictors of meeting the standard in these domains, ratings were collapsed into two groups: those having the standard met (i.e. those categorised as: "Exceeds expectation", "Meets expectation", or "Not applicable) and those failing to reach the standard (i.e. those categorised as either "Some improvement required" or "Significant improvement required"). The table below gives the percentage of participants where their case files were rated as meeting the standard in their vocational rehabilitation journey, together with these percentages partitioned by active case length (defined by duration of compensation as per the sampling frame strata).

Table 15 Percentage of participants where the file rated as meeting the standard, together with these percentages partitioned by weeks of compensation.

	Overall n=547 %	Strata (weeks compensation) 3-12 n=119 %	13-26 n=138 %	27-52 n=146 %	>52 n=144 %	P*
Claimant centeredness	25.8	16.8	18.1	32.2	34.0	<0.001
Expectation setting	33.3	15.1	37.7	34.9	42.4	<0.001
Claimant accountability	58.1	49.6	57.2	67.1	56.9	0.04
ACC communication with the claimant	27.6	18.5	26.8	30.8	32.6	0.05
Team makeup	33.6	15.1	34.1	39.0	43.1	<0.001
Information gathering	28.2	11.8	31.2	30.1	36.8	<0.001
Whole team communication	19.0	10.1	18.8	19.9	25.7	0.01
Relationship building and maintenance	26.3	11.8	23.2	38.4	29.2	<0.001
Implementation of plan/decision making	26.9	12.6	28.3	32.2	31.9	<0.001
Evaluation and monitoring	24.9	13.4	22.5	28.1	33.3	0.001
Overall timeliness	28.7	27.7	33.3	28.8	25.0	0.49
Overall appropriateness	27.2	16.0	21.7	34.9	34.0	<0.001
ACC facilitation of *maintaining* work role	30.9	15.1	23.2	35.6	46.5	<0.001
ACC facilitation of *obtaining* work role**	85.6	97.5	95.7	84.9	66.7	<0.001
ACC facilitation of *regaining* work capacity**	92.9	99.2	98.6	95.2	79.9	<0.001

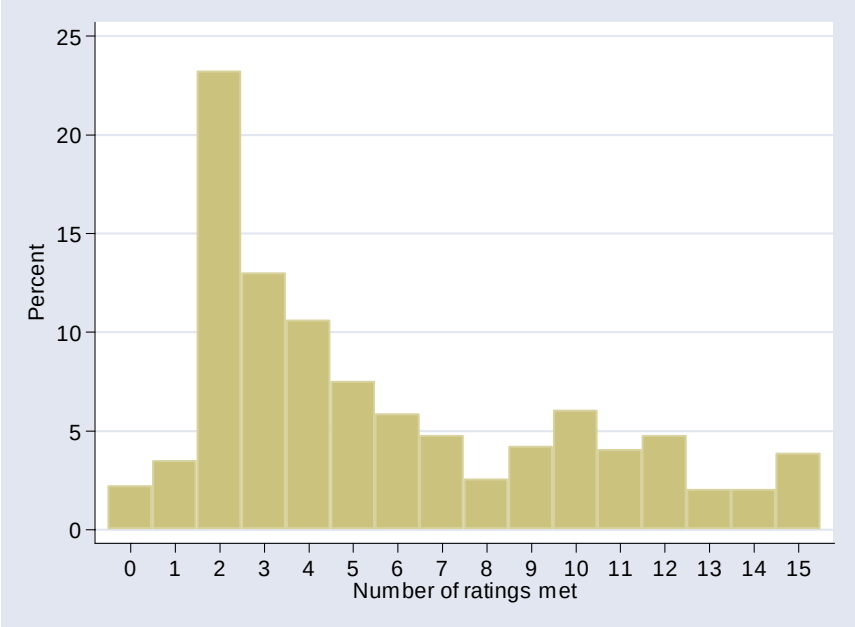
*P-values calculated using Fisher's exact test.

** the % meeting the standard includes those for whom this domain was not applicable.

Apart from "Overall timeliness", the distribution of participants that had their case rated as meeting the standard in their vocational rehabilitation journey was significantly different across the strata. In many of the comparisons, those in the 3-12 week stratum were less likely to be rated as meeting the standard in their Vocational Rehabilitation Journey than those in the 27-52 week and >52 week strata.

Figure 3 gives the distribution of the total number of components where claimant files were rated as meeting the standard. A claimant who was rated as meeting the standard in all 15 variables would have a score of 15 while a claimant who was rated as meeting the standard in none of the 15 variables would have a score of 0.

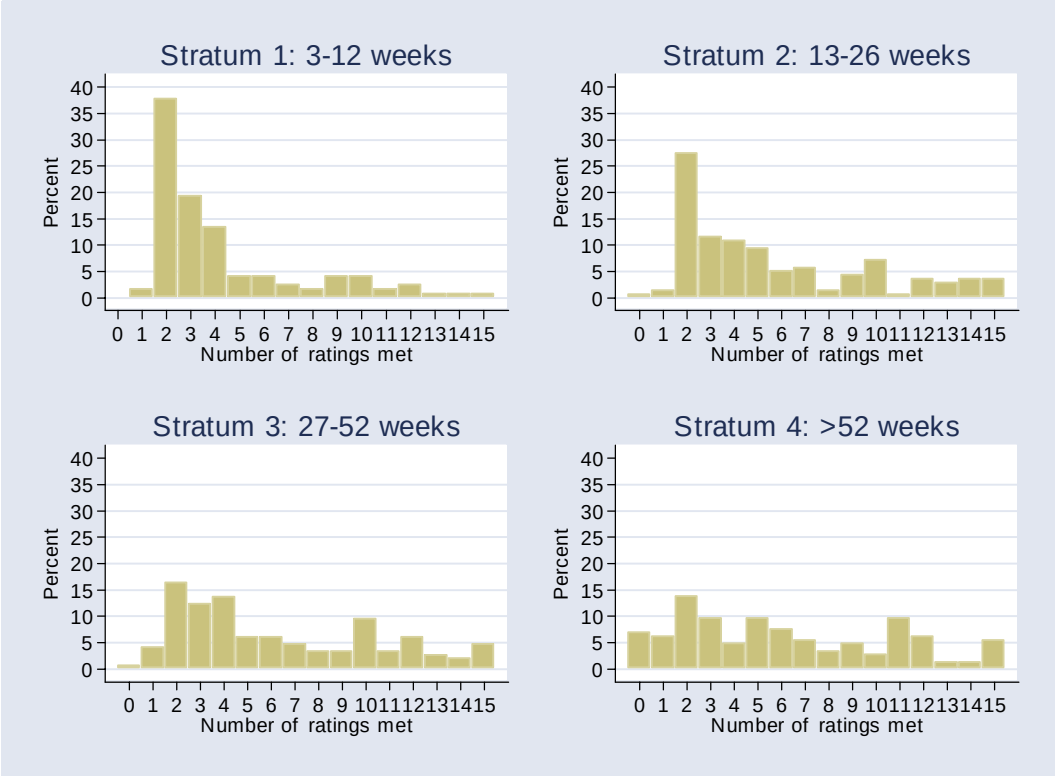
Figure 3 Overall distribution of the number of the 15 ratings met by participants.



Overall, 21 (3.8%) participants were rated as meeting all 15 criteria while 12 (2.2%) reported meeting none. Median number of criteria met was 4, with IQR 2, 9.

The figure below indicates the distribution of total number of components where claimant files were rated as meeting the standard according to each stratum separately.

Figure 4 Distribution of the number of the 15 ratings met by participants by strata.



The clear differences seen between strata are significant (P<0.001).

Relating potential predictor variables to dichotomised ratings

Due to the repeated nature of the data (i.e. each participant had 15 variable components defined as an evaluation of the claimant's Vocation Rehabilitation Journey), a generalized estimated equations (GEE) approach was used to estimate parameters and test for significance. Candidate predictor variables (i.e. the socio-demographics and relevant injury characteristics of the participants appear in Table 1). An unstructured correlation matrix was used and robust variance estimate techniques were used to calculate standard errors and confidence intervals. All analyses were performed using Stata version 8.0.

Table 16 Crude analysis relating predictor variables separately to participants dichotomised ratings of their Vocational Rehabilitation Journey using GEE analysis after adjusting for the design stratification variable (weeks compensation). Note that we model the event of interest being vocational rehabilitation as meeting the standard.

	Estimate	(95% CI)	P
Gender			0.22
Female	0	reference	
Male	-0.09	(-0.24, 0.06)	
Age			0.02
<40	0	reference	
40-49	0.16	(-0.03, 0.35)	
50-59	0.06	(-0.14, 0.25)	
≥ 60	0.08	(-0.12, 0.28)	
Ethnicity	33 (6.0%) participant observations missing		0.09
Maori	-0.32	(-0.58, -0.05)	
Pacific	0.15	(-0.45, 0.74)	
Asian	-0.18	(-0.64, 0.27)	
European/other	0	reference	
Injury site category			0.04
Back/Spine	0	reference	
Lower limb	0.20	(0.00, 0.39)	
Upper limb	0.17	(-0.04, 0.38)	
Head	0.59	(0.16, 1.02)	
Abdomen/Pelvis/Chest	0.37	(0.01, 0.74)	
Number of prior claims	31 (5.7%) participant observations missing		0.74
0-4	0	reference	
5-7	-0.07	(-0.26, 0.12)	
8-12	0.03	(-0.16, 0.21)	
≥13	-0.07	(-0.27, 0.13)	
Work related injury			0.04
No	0	reference	
Yes	-0.15	(-0.30, -0.01)	
Number of case managers Year 1	17 (3.1%) observations missing		0.002
0	-0.16	(-0.40, 0.07)	
1	0	reference	
2	-0.17	(-0.34, 0.01)	
≥ 3	-0.34	(-0.51, -0.16)	

Key interpretation of dichotomised rating data:

- There is no difference in whether the standard is met between sexes or the previous number of claims made.
- Age was significantly associated with whether the standard was met. In particular – those who were <40 years were less likely than those ≥ 40 years to have the standard met.
- while 'ethnicity', as a whole, was not statistically significant, Maori were significantly less likely than the reference category (i.e. European/other) to have the standard met. However, we must be cautious in interpreting this as the numbers of non-European/others was so low.
- Injury site category was significantly associated with having standards met. Specifically, those with back and spinal injury appeared to least likely to have the standard met, while those with head injury appeared to most likely have their expectations met.
- Those participants who sustained their injury at work were significantly less likely to meet the standard than those sustaining their injuries elsewhere (see Appendix 3c for further analyses).
- The number of case managers assigned was associated with expected standards being met. Those with one manager assigned appeared to most likely to meet the standard while those with 3 or more case managers were least likely to.

Outcome measure data related to global domain scores

Short Form 36 Questionnaire (SF36), Personal Capacities Questionnaire (PCQ) and the Global Domain evaluation of the claimant's Vocation Rehabilitation Journey

The relationships between the component variables for each of the three measures appears in the table overleaf. For the purposes of this report, we define the absolute value of a correlation between 0-0.3 as being weak, 0.31-0.7 as being moderate, and 0.71-1 as being strong.

Table 17 Matrix of Spearman's correlation coefficient for the Global Domains of claimant's Vocation Rehabilitation Journey, SF36, and PCQ.

	15 Global Domains of the claimant's Vocation Rehabilitation Journey																SF36		
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15		Phy	Men	PCQ
Q1	1	0.49	0.29	0.51	0.39	0.43	0.35	0.48	0.49	0.44	0.49	0.64	0.53	0.09	0.02		-0.01	0.01	0.02
Q2		1	0.38	0.45	0.37	0.45	0.40	0.46	0.47	0.41	0.36	0.41	0.41	-0.01	0.03		-0.02	0.05	0.02
Q3			1	0.32	0.26	0.23	0.25	0.38	0.26	0.27	0.34	0.31	0.25	0.07	0.07		0.06	0.07	-0.06
Q4				1	0.42	0.44	0.44	0.67	0.41	0.45	0.40	0.46	0.44	0.04	0.09		-0.04	-0.04	0.04
Q5					1	0.56	0.56	0.43	0.43	0.47	0.28	0.48	0.50	0.02	0.09		-0.10	-0.02	0.08
Q6						1	0.43	0.42	0.40	0.49	0.30	0.44	0.50	-0.02	0.03		-0.08	-0.08	0.08
Q7							1	0.42	0.41	0.41	0.31	0.42	0.44	0.03	0.03		-0.06	-0.10	0.09
Q8								1	0.41	0.42	0.29	0.45	0.43	-0.01	0.07		-0.07	-0.04	0.08
Q9									1	0.45	0.50	0.47	0.46	0.11	0.07		0.01	-0.01	-0.01
Q10										1	0.33	0.53	0.55	0.08	0.03		0.03	-0.03	-0.01
Q11											1	0.47	0.37	0.18	0.11		0.08	0.09	-0.07
Q12												1	0.66	0.13	0.11		0.01	-0.01	-0.01
Q13													1	-0.06	-0.05		-0.06	-0.09	0.09
Q14														1	0.53		0.25	0.21	-0.34
Q15															1		0.20	0.22	-0.28
Phy																	1	0.25	-0.64
Men																		1	-0.40
PCQ																			1

Those correlations considered 'weak' – indicating a low relationship are highlighted in grey shading

Within measure correlations. From Table 17 it can be seen that there is weak to moderate correlations between the majority ratings for Domain1 through to 13 (with correlations ranging between 0.23 and 0.67) and moderate correlation between 14 and 15 (correlation 0.53). Weak correlations are noted between a number of domains and Domain 3 (Claimant Accountability) and all domains and Domain 14 and 15[13] with correlations ranging between (-0.06, 0.18) as highlighted. A weak correlation was also found between the mental and physical components of the SF36 (correlation 0.25).

Between measure correlations. The correlations between the Global Domain scores defined as making the claimant's Vocation Rehabilitation Journey (Q1-Q15) and SF36 measures (Phy and Men) were all weak, ranging from -0.10 to 0.25. Apart from the estimated correlation between Q14 and the PCQ score (correlation -0.34), this weak pattern of correlation was also seen between the Global Domain scores (defined as making the claimant's Vocation Rehabilitation Journey) and the PCQ measure. Finally, a moderate negative correlation was seen between the PCQ measure and both components of the SF36 as would be expected.

Whilst these relationships might suggest that there is little connection between health state, function and quality of life with the individual Global Domains, caution should be exercised for a number of reasons. Further analyses indicate that indeed overall performance on the Global Domains is indeed linked to return to work outcome (see Tables 18 and 19)

Associating outcome measures with work status (at time of survey)

Each of the three outcome measures were explored in association with claimants' response to the question "Are you working now? Yes/No". Complete information for all variables (i.e. all Short Form 36 questionnaire (SF36), Personal capacities questionnaire (PCQ), Global Domain scores (aiming to capture the quality of the the claimant's Vocation Rehabilitation Journey and return to work question) was available for 457 participants, and was used in the pursuant analyses. Only the first 13 of the 15 Global Domain scores were utilised because of the high level of "not applicability" associated with these questions (see Table 2) that was directly related to the return to work question (ie actions to obtain or regain work).

[13] The weak correlations for these two variables is likely to be connected to the fact that they were applicable only to the subset of claimants where obtaining or regaining work was relevant.

Table 18 provides the frequencies (percentages) of current work status at the time of questionnaire for all the complete cases (n=457) and for the weeks case active stratifications. Overall, 16% of complete cases had not returned to work at the time of the survey and this return rate was significantly dependent over strata (P<0.001).

Table 18 Current work status at the time of questionnaire elicitation for all the complete cases (n=457), together with the distributions within each stratum.

	Strata (weeks case active)										
	Overall		3-12		13-26		27-52		>52		
	n	(%)	n	(%)	n	(%)	N	(%)	n	(%)	P*
Are you working now?											<0.001
Yes	386	(84)	92	(95)	105	(89)	109	(87)	80	(68)	
No	71	(16)	5	(5)	13	(11)	16	(13)	37	(32)	

*P-value calculated using Fisher's exact test.

Due to the dichotomous nature of the return to work variable, logistic regression was employed to associate the three outcome measures with the current work status question. The continuous variables within the SF36 and the PCQ measures were categorised using conventional epidemiologic logic and practice. Such categorisation eliminates the effect of skewness and avoids the linear assumption across the full value range of these continuous variables. Continuous variables were categorised into quartiles around the values presented in Table 10.

Initially crude analyses were conducted, looking at each of the measures separately. Then a combined multivariable model was developed to ascertain whether each of the three measures independently predicted the return to work variable – or whether one or two of these measures where adequate. This assessment used the Akaike's Information Criterion (AIC). The AIC is an information criterion which considers both the complexity of the model (penalizing models with too many variables) and its goodness-of-fit to some data. The preferred model balances these competing demands and is the one with the lowest value of the criterion. We use Nagelkereke's r^2 value to estimate the amount of the variability explained in the return to work variable by the outcome measures, and Hosmer and Lemeshow's goodness-of-fit statistic to assessment whether the statistical model adequate fits the observed data.

Table 19 Logistic regression analyses relating the three "outcome" measures to current work status for participants with complete information (n=457), after adjustment for the stratified design variable (weeks compensation).

	Nagelkereke's r^2	Akaike's Information Criteria (AIC)	Hosmer-Lemeshow goodness-of-fit P
Baseline model (intercept and strata)	0.12	370.91	0.99
Models with single "outcome" measure (and intercept and strata)			
SF36	0.27	328.55	0.49
PCQ	0.22	341.94	0.43
Components defined as making the claimant's Vocation Rehabilitation Journey (Q1-Q13)	0.22	365.34	0.30
Models with "outcome" measure pairs (and intercept and strata)			
SF36 and PCQ	0.36	307.24	0.58
SF36 and Components defined as making the claimant's Vocation Rehabilitation Journey (Q1-Q13)	0.38	326.61	0.63
PCQ and Components defined as making the claimant's Vocation Rehabilitation Journey (Q1-Q13)	0.41	312.68	0.03
Model with all three "outcome" measures (and intercept and strata)			
SF36, PCQ and Components defined as making the claimant's Vocation Rehabilitation Journey (Q1-Q13)	0.46	307.01	0.86

The above table shows that each of the three considered "outcome" measures improves the baseline model (based on the AIC criterion) and, indeed, the model that includes all three simultaneously, is the best. This final multivariable model explained 46% of the variability in the return to work variable and adequately fitted the observed data (based on the Hosmer-Lemeshow goodness-of-fit test). The inclusion of all three "outcome" measures in the final model implies that all these measures are importantly related to return to work yet each captures a separate dimension or component of this variable.

Specialist occupational assessment review

30 claimant files were reviewed by Sarah Travaglia, Bernadette Ryan and Linda Hall. Of these files there were 30 Initial Occupational Assessments (IOAs) and 8 Vocational Independence Occupational Assessments (VIOAs) were reviewed.

Summary of findings

Qualitative Synopsis

- It was apparent on many files that the IOA and VIOA process had been used by the Case Managers as a 'process' in order to obtain an exit from the scheme and may not necessarily have been the best option (or the most timely outcome) for ACC and/ or the claimant. There were some files where the reviewers felt (and there was evidence of) that a 'return to work' outcome could have been achieved without the IOA and VIOA process taking place and these assessments had shifted the focus prematurely from maintaining the original position.
- There appeared to be a generalised lack of emphasis on 'maintaining' the claimant's current employment. It was evident on some files that if early intervention had had a stronger emphasis on job task analysis, work place assessment and a case conference with the employer early in the claimant's incapacity, that his or her return to work may have been expedited. On some files there was evidence of early worksite assessment and input from the employer but this information appeared to have little application and was not utilised.
- The comprehensiveness of the assessments carried out varied significantly between IOA and VIOA Assessors. Although ACC guides the Assessors with a standard template for assessments, it is evident that the depth of content is variable dependent on the Assessor.
- Identification of the claimants' transferable skills in the IOAs needed improvement. Commentary as to how the skill was deemed to be transferable was scant and/or seemingly inappropriate in some assessments.
- Strategies to assist the claimant in preparing for the identified work types required improvement. Many of the strategies were repetitive and lacked

individuality. It even appeared that they had been ‘cut and pasted’ and duplicated under each work type.

- Claimant barriers in returning to work were well identified in some assessments, but poorly identified in others. For example, one file was identified where the claimant had a criminal conviction and was disqualified from driving, but this had not been identified as a barrier in the IOA.
- There was evidence of a poor relationship between the claimant’s work experience, skill base and the job options/ work types identified in some instances. An example of this was the identification of a work type as a Social Worker when the claimant did not appear to hold a social work qualification. Another example included light driving being identified as a work type, when the claimant was still disqualified from driving for the next 12 months. A further example was a suggestion of active police work for a 59 year old woman simply because she has participated in voluntary police work historically.
- There was minimal evidence that the claimants Individual Rehabilitation Plan was discussed or considered when completing the IOA or VIOA. There was even one file that reflected minimal engagement of the claimant in identifying suitable work options, but included several claimant comments expressing the claimant’s desire to move to study and self employment far removed from his previous work history. This would appear to set an expectation that is not congruent with the vocational hierarchy in the schedules of the Act.
- It was difficult to accurately determine the level of communication between the Assessors and ACC, as the specialist review panel viewed only the hard copy notes and did not access Pathway. The review panel acknowledges that some of this correspondence may have been evident on Pathway.
- It was positive to note that in almost all cases, the claimant had an opportunity to comment on the work types /job options and this was included in the report.
- None of the files reviewed demonstrated that cultural needs were either required to be considered during the assessment process, nor was there any evidence of this being offered.

- In general, the quality of the VIOAs appeared to be better than the IOAs.
- A general observation from the files reviewed (in totality) is that on occasion, there was evidence of key issues/ barrier being overlooked in regard to the claimant's rehabilitation. An example of this was a person who had received every clinical intervention possible for a carpal tunnel injury and resultant chronic pain syndrome, but there was no evidence of a discussion with the claimant that they had a body mass index of 36 (obese) and that this may have been a significant factor hindering his or her progress. These contextual factors are clearly an important consideration for a 'whole of person' assessment and management.

Quantitative Synopsis

1) Timeliness of Assessments: Because the review panel were viewing hard copies of files only, in some cases it was difficult to determine exact dates of referrals. There is a possibility that some of these may have been electronically stored on Pathway.

The general trend however, is that there was a significant amount of assessments and reports that were not completed within the timeframes specified by the ACC contract and service specification.

The contracted timeframes are as follows:

<u>IOA</u>
- Assessor to contact ACC Case Manager within 2 working days if unable to contact claimant.
- Assessor to meet with claimant within 5 working days of receipt of referral.
- Assessor to complete the assessment within 10 working days of commencement of assessment.

<u>VIOA</u>
- Assessor to contact ACC Case Manager within 5 working days if unable to contact claimant.
- Assessor to meet with claimant within 10 working days of receipt of referral.
- Assessor to complete the assessment within 8 working days of commencement of assessment.

The following figures illustrate findings in relation to contracted timeframes.

Figure 5 Assessor timeliness on IOA and VIOA

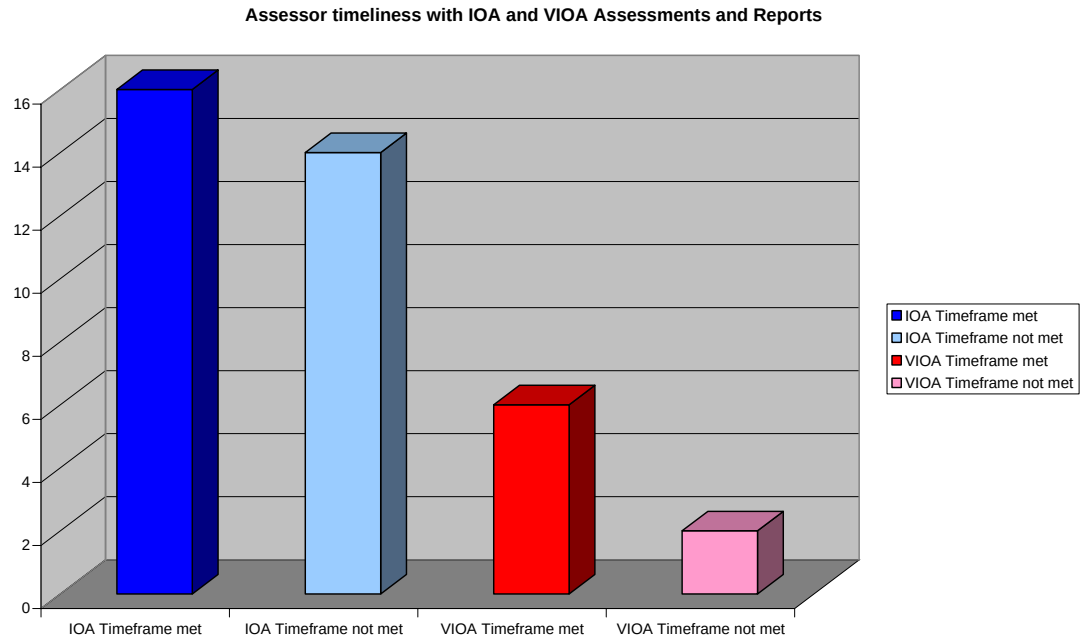


Figure 6 Percentage of contractual timeframes met for IOA

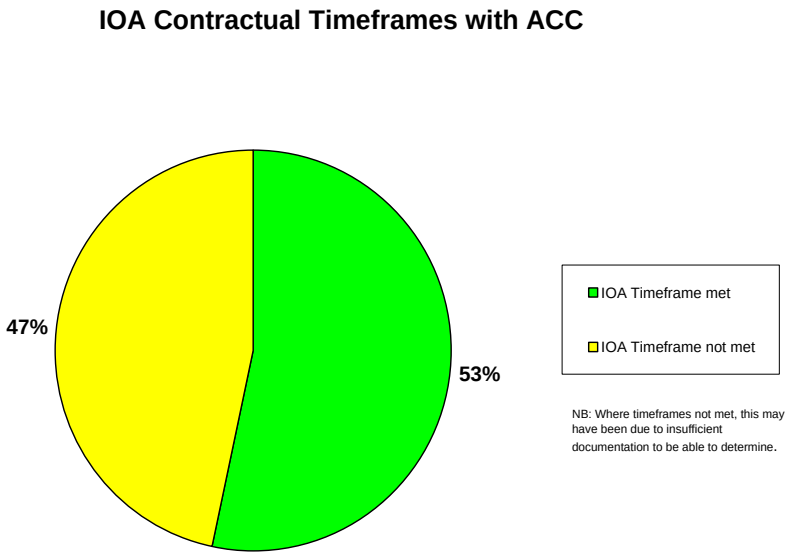
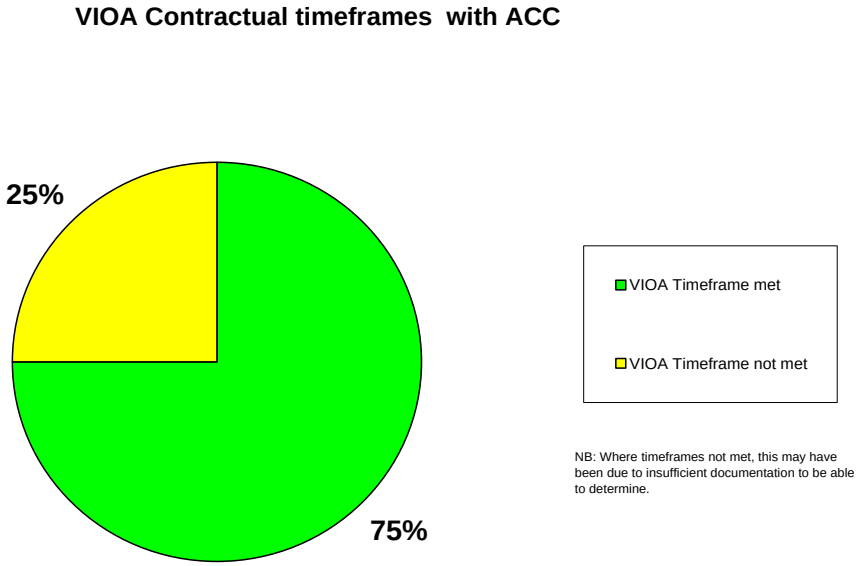


Figure 7 Percentage of contractual timeframes met for VIOA



2) Work Experience 26 out of 30 IOAs meet requirements with a good description of the claimants work history and employment.

1 out of 30 IOA's was deemed to have exceeded expectations, as the work history was extensively and clearly outlined.

3 out of 30 IOAs were deemed to need some improvement such as only minimal details were included and a lack of chronological order to the job history making it difficult to interpret.

3) **Education** 7 out of 30 IOAs needed improvement in the area of recording claimants' educational details. This was either because the information provided was minimal or the qualification stated was not clear. The remaining 23 assessments met requirements.

4) Transferable Skills 4 out of 30 IOAs exceeded requirements as the transferable skills were extensively documented and comprehensively described.

19 out of 30 IOAs met requirements and the transferable skills were adequately listed.

7 out of 30 IOAs needed some or significant improvement, as there was minimal detail as to how the skill had been justified or identified as transferable. The skill had often not been transferred into a competency.

Most of the eight VIOA's appeared to have met requirements, with only one being identified as needing improvement.

5) Work Types 20 out of 30 IOAs had the work type listed adequately.

10 out of 30 IOAs needed some or significant improvement. There were some examples where the review panel believed inappropriate work types had been identified eg a receptionist in a hair salon had a work type of "General Manager" identified.

6) Strategies for preparing for work

2 out of 30 IOAs exceeded requirements in the area of strategising for preparing for work. This was because the strategies were very realistic, highly individualised and it was obvious that considerable effort had gone into this area of the assessment.

14 out of the 30 IOAs met requirements.

14 out of the 30 IOAs needed some or significant improvement. This was the area where it was evident that some assessors were duplicating strategies and writing the same strategy for up to 20 jobs.

7) Work type job sheets

These were all completed adequately on all assessments reviewed and are a standardised document dependent on the coding.

8) Barriers to returning to work

This is one of the most important areas of the assessment in which the assessor identifies barriers that could prevent the claimant from returning to work. Yet it was evident from the result that a significant number of these assessments needed improvement.

19 out of 30 IOAs identified claimant barriers adequately.

11 out of the 30 IOAs were assessed as needing some or significant improvement. Items such as restricted driving licenses, disqualified driving licenses, incomplete qualifications and criminal convictions had been missed from the barrier identification area.

9) Curriculum Vitae

This area was not able to be reviewed from an IOA Assessor perspective, as some claimants had either completed their own CV or had the CV completed by another provider. There were only a small number where ACC had requested the CV. Those that were available were of average standard. A concern worth noting was that one claimant had completed his or her own CV with inappropriate detail and errors and there was no evidence that during the rehabilitation process, any advice had been given to the claimant to amend the CV or have it professionally prepared.

10) Cultural Competency

None of files reviewed had any evidence of cultural appropriateness being considered or required by the claimant (and cases had been selected to include Maori, Pacifikan and Asian claimants).

11) Communication

It was difficult to quantitatively analyse the level of communication between ACC, the claimant and the Assessor, as the review team were working from the hard copy file only (no access to Pathway).

Specialist medical assessment review

30 claimant files were reviewed by two occupational health physicians (Dr Des Gorman and Dr Kathleen Callaghan). These files contained Initial Medical Assessment (IMAs) or both IMAs and Vocational Independence Medcial Assessments (VIMAs). An IMA/VIMA Best Practice Checklist (designed by Pegasus) had been supplied in order to assist with the review.

Summary of findings

Qualitative Synopsis

It rapidly became apparent during the review that the recommended checklist supplied (the IMA/VIMA Best Practice Checklist) was of limited use for this particular task. The checklist would appear to be a useful tool to assist with audit of process – that is, whether or not information on a particular topic (legally required to be included in an IMA/VIMA) is present or absent providing a 'peer reviewer' with the opportunity to assess whether the information provided by the assessor is satisfactory or not.

The issue of adequacy of the information on which any decision is based is critical. From the perspective of our assessors (physicians practicing from an evidence-based paradigm), full determination of the adequacy of the information provided by an assessing doctor requires access to all the medical information of relevance to the case. However, this was not always possible with many cases the paper-based files did not contain the original claim information provided by the claimant and the doctor. This may have been available on Pathway but although the reviewers did not have access to this, it is important to note that it is the information readily available to the assessor conducting the IMA/VIMA that is critical – not the information that exists but is practicably inaccessible (ie Pathway).

The main findings were that:

(1) Most assessors operated from a very biomechanical perspective and therefore did not appear to take into account significant non-somatic elements contributing to disability and hence medical fitness to work.

For example:

- Loose description only regarding ‘previous injury’ which in one case when investigated by the review panel had occurred 15 years prior to the current claim and resulted in 12 years on compensation.
- Minimal radiological findings with a normal clinical examination and no mention that the occupational assessor had commented that the patient “has no interest in returning to work again”.
- MRI reported degenerative change at C3/4, C5/6 and left C6/7 – all attributed to injury that could not have caused such widespread change. Impact of recent death of wife not explored.
- Strong history of somatisation and catastrophic illness beliefs not explored or collateral history from rheumatologist.
- Conclusions of post TBI psychometric report not explored.
- Concomitant personal grievance with employer not explored (x2)

As a result, the assessors (a) rarely identified the nature of any existing disability which had non-somatic elements and (b) proposed diagnoses which did not adequately explain the symptoms, signs and results of investigations at the time of the assessment.

(2) Several assessors failed to explore the impact of other diagnoses on overall disability, for example, cardiac conditions, diabetes or psychiatric conditions.

(3) One report was internally inconsistent, stating that the patient could not be a police officer because of safety-related issues but could be a security officer (despite both jobs having similar tasks and risk for physical harm).

Of all these reports (22/30) were categorised by the reviewers as below acceptable or poor.

Quantitative Synopsis

All files were qualitatively assessed by two reviewers (DG and KC). The basis for the categorisation was the IMA Best Practice Checklist, but due to the reasons outlined above, the following criteria were added.

a) the medico-legal details were assessed against all the medical information provided to the reviewers in the claimant files. Ratings awarded by the reviewers were based on the correlation between the information provided in the IMAs/VIMAs and that available from other sources. That is, did the medico-legal details in the IMAs/VIMAs provide a complete summation of what was available across all the medical sources contained on file?

b) Similarly, logic/conclusions were rated as to whether they could be medically justifiable based on all the information contained on the claimants file- rather than merely the information included in the assessor's report.

In essence, the IMA Best Practice Checklist assesses internal consistency. Our rating of the files expanded assessment to include consistency of the IMA/VIMA with other external health professional documentation.

c) In addition, the reviewers rated the files in keeping with best-practice rehabilitation as per the published literature. It should be noted that this does not necessarily correlate with the ACC instructions to VIMA assessors – who are asked to consider the work capacity in terms of the personal injury for which the claimant has entitlement/cover.

Of the files reviewed:

- 6 of the 30 were categorised as good
- 2 of the 30 were categorised as satisfactory
- 9 of the 30 were categorised as below acceptable
- 13 of the 30 were categorised as poor

Examples

The following examples are provided to assist with understanding the qualitative and quantitative analyses above.

Example 1

From IMA report, section entitled "discussion and opinion": "Mr. [x] does still suffer with significant pain form his back, which causes some problems to both legs. The rehabilitation is discussed above. From a work perspective he would struggle in work with a heavy physical demand or in work requiring him to be performing much heavy lifting. Some ability to change position and work from either a seated or standing position would be desirable".

The medical capacity to work is clearly seen in very biomechanical terms. However, one month following this report, a pain assessment identifies the following potential barriers to effective rehabilitation and management:

- "Physical deactivation
- Overly mechanistic model for his physical status
- Possible sense that his situation might not have been adequately diagnosed and that further intervention might be possible
- Hurt/harm beliefs
- Avoidance of movement out of fear of pain or re-injury
- Difficulties with sleep, which might be around a disrupted schedule
- Low level of active coping skills
- Possible issues around alcohol overuse
- Possible anxiety issues
- Previous impulsive suicide attempt, although not currently suicidal".

From the reviewers' perspective this list of barriers to rehabilitation are highly significant and include non-somatic factors as well as other medical conditions (eg: alcohol overuse, previous suicide attempt). Whether or not these factors are injury related was not explored during this review.

Example 2

The covered injury is described as an injury to a cervical disc. The VIMA states "at this time Mr. [X] should continue to avoid any employment which requires heavy

lifting, pushing, pulling or carrying or prolonged or repetitive use of his arms outstretched or away form his body. Work that requires repetitive twisting of his neck would also be unsustainable or untenable for him". The VIMA also notes that Mr. [X] suffers from depression for which he is currently taking medication.

Many of the jobs identified as medically appropriate stipulated "good cognitive functioning" eg: sales assistant, telephone switchboard operator, clerk, business service representative etc. It is known that depression can cause cognitive problems the extent of which were unexplored by the assessor in this particular claimant's case. As reviewers we simply raise this as a dilemma confronting the assessor (and ACC): a non-injury related condition can render a claimant without medical 'fitness' for any role/task in a practical sense while the injury related condition places limitations on certain roles/tasks only.

Example 3

In contrast the following is provided as an example of a good report from the reviewers' perspectives.

"However, I don't feel the plateauing of his symptoms in the last six weeks has occurred entirely for injury related reasons. While the current return to work is appropriate from the physical perspective it does not address the non-injury related factors that are also felt to exist and I am uncertain as to what extent these have been, or are being, directly addressed" The report continues to expand on these non-injury related factors and plan for more holistic rehabilitation.

Summary

Review of the IMAs and VIMAs contained within 30 ACC claimant files showed significant room for improvement. There is a predominant focus on a biomedical model rather than a holistic approach to vocational rehabilitation resulting in (a) diagnoses that do not explain the entire patient presentation and (2) failure to identify (and hence address) barriers to return to work.

Claimant interviews

A subset of thirty claimants who took part in the survey and/or case note review who indicated they would consider being interviewed were contacted following completion of the questionnaire and case note review. Participants were selected to represent a range of characteristics (age, gender, injury type, period of compensation, outcome) and a range of 'quality' of vocational rehabilitation (where review indicated vocational rehabilitation had predominately met the defined standard versus predominately not met the defined standard).

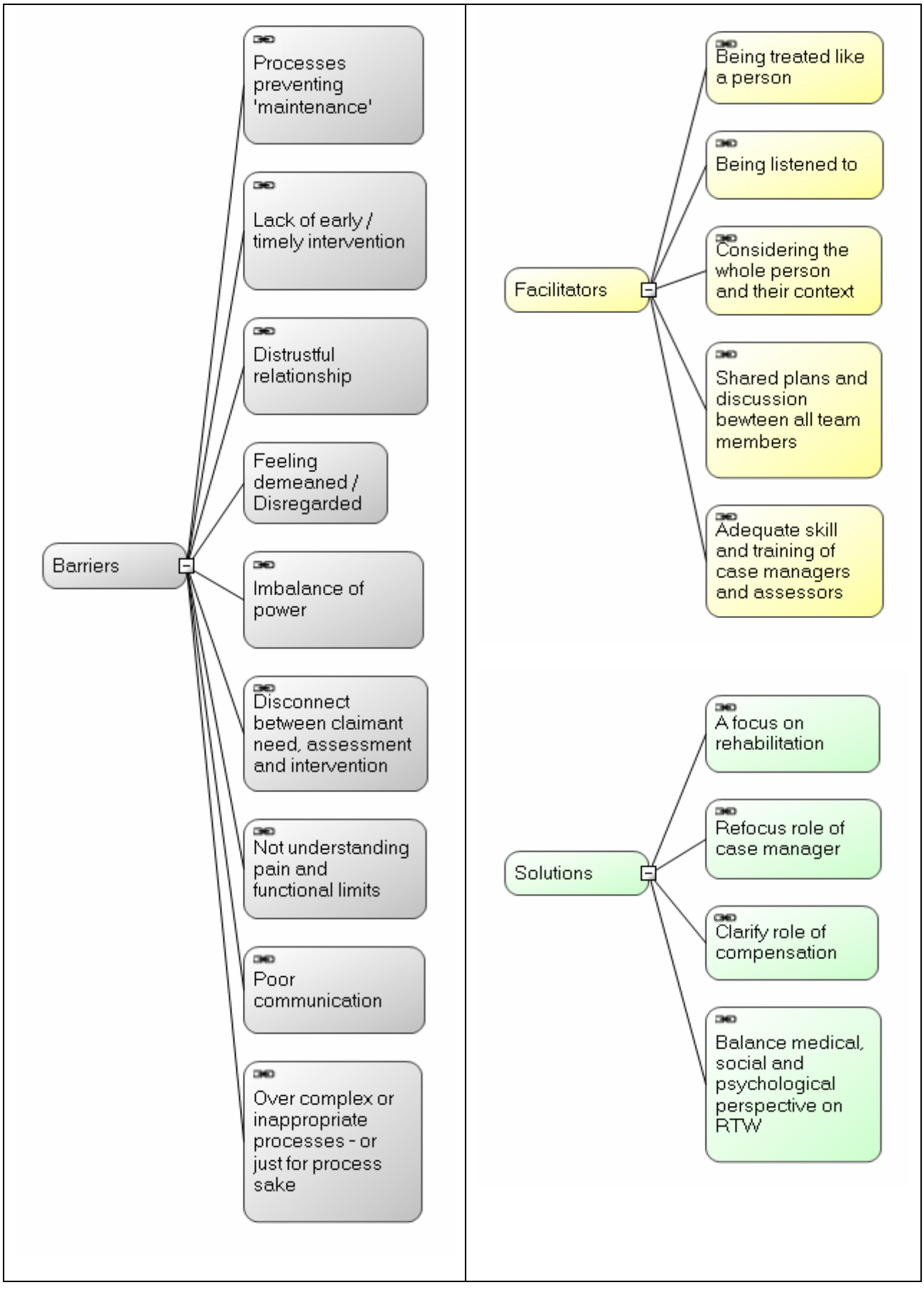
The majority of those who consented to the study indicated they would be willing to be interviewed. Three participants approached to take part in the interview refused (largely due to time commitments). Demographics of the participants who agreed to take part are shown in the table overleaf.

Analysis indicated a great deal of agreement about the core issues that act as both barriers and facilitators to the vocational rehabilitation process from the claimant's perspective. Findings are presented below according to the two domains of Barriers and Facilitators. Finally – a number of extracts from claimants' interviews encompass ways vocational rehabilitation processes could be improved in ways that go beyond identification of barriers and/or facilitators. These 'solutions' are also presented. Data for each of these is presented in the form of direct quotes from the interviews with claimants.

Table 20 Interviewee details

Our ID	Region	urban	Reason selected	Injury site	Strata	Ethnicity	Outcome	Agegroup	Gender
28	Accredited employer	rural	Accredited Employer - Bad Exp	Lower Limb	52 plus	NZ European / Pakeha	CLOSED	Over 60	M
190	Accredited employer	rural	Accredited Employer - Good Exp	Back/Spine	13 to 26	NZ European / Pakeha	CLOSED	40 to 49	M
406	Accredited employer	urban	Cultural - Maori & family	Upper Limb	52 plus	NZ European / Pakeha	OPEN	40 to 49	M
16	Auckland and the North	urban	Cultural - Maori	Back/Spine	52 plus	NZ Maori	OPEN	40 to 49	M
134	Auckland and the North	urban	Psycho-social issues	Back/Spine	52 plus	NZ European / Pakeha	OPEN	40 to 49	M
163	Auckland and the North	urban	re-injury/claimant responsibility	Upper Limb	27 to 52	NZ European / Pakeha	CLOSED	40 to 49	M
297	Auckland and the North	urban	pain syndrome and family	Upper Limb	52 plus	Other	OPEN	60 to 65	F
305	Auckland and the North	urban	Good Experience	Head	52 plus	NZ European / Pakeha	OPEN	40 to 49	M
351	Auckland and the North	rural	Self-employed	Back/Spine	13 to 26	NZ European / Pakeha	CLOSED	40 to 49	M
555	Auckland and the North	urban	Red Flags	Upper Limb	03 to 12	NZ Maori	CLOSED	30 to 39	M
579	Auckland and the North	urban	Cultural - Chinese	Lower Limb	27 to 52	Chinese	CLOSED	40 to 49	F
44	Canterbury	rural	Bad experience	Head	27 to 52	Not Stated	CLOSED	40 to 49	M
243	Canterbury	rural	Part-timer	No data	27 to 52	NZ European / Pakeha	CLOSED	30 to 39	F
308	Canterbury	urban	Bad experience	Lower Limb	52 plus	NZ European / Pakeha	OPEN	50 to 59	F
388	Canterbury	urban	Self-employed	Lower Limb	13 to 26	NZ European / Pakeha	CLOSED	50 to 59	M
455	Canterbury	urban	Good Experience	Head	27 to 52	NZ European / Pakeha	CLOSED	30 to 39	F
502	Canterbury	urban	Lower Back problems	Back/Spine	52 plus	NZ European / Pakeha	CLOSED	40 to 49	F
229	Central North Island	rural	Self employed good exp	Lower Limb	27 to 52	NZ European / Pakeha	CLOSED	Over 60	M
317	Central North Island	rural	Bad experience	Lower Limb	27 to 52	NZ European / Pakeha	CLOSED	Over 60	M
529	Central North Island	rural	Sub-contractor	Lower Limb	27 to 52	NZ European / Pakeha	CLOSED	Over 60	M
586	Central North Island	rural	Good Experience	Lower Limb	13 to 26	NZ European / Pakeha	CLOSED	40 to 49	M
43	Waikato, Bay of Plenty	rural	Self-employed	Upper Limb	13 to 26	NZ European / Pakeha	CLOSED	50 to 60	M
268	Waikato, Bay of Plenty	urban	Older Person	Back/Spine	52 plus	NZ European / Pakeha	OPEN	Over 60	M
272	Waikato, Bay of Plenty	rural	location difficulties, VI	Upper Limb	52 plus	NZ European / Pakeha	OPEN	40 to 49	M
67	Wellington Region	urban	Part-timer	No data	27 to 52	NZ European / Pakeha	CLOSED	Over 60	F
498	Wellington Region	urban	Bad experience	Back/Spine	27 to 52	NZ European / Pakeha	CLOSED	20 to 29	M
94	West Coast & Otago	rural	Self-employed	Upper Limb	27 to 52	Other	CLOSED	Over 60	M
167	West Coast & Otago	rural	Bad experience	Lower Limb	13 to 26	NZ European / Pakeha	OPEN	40 to 49	M
311	West Coast & Otago	rural	Bad experience	Back/Spine	52 plus	NZ European / Pakeha	OPEN	30 to 39	F
440	West Coast & Otago	urban	complex case	Back/Spine	52 plus	Declined to answer	CLOSED	40 to 49	M

Figure 8 Factors identified by claimants on interview



Barriers

A wide range of barriers were identified but we note in the figure above and the summary below those where there was a particularly emphatic response from claimants and where the topic appeared to link to potential impact on delivering vocational rehabilitation according to the aims and intent of the Act.

Although we attempted to select claimants for interview with varying experiences of vocational rehabilitation (based upon the case note review findings and the survey) the majority raised significant issues of concern that we have aimed to capture below.

The opening comment from one claimant (297) reflects a sense that a number of claimants expressed about their vocational rehabilitation:

> *I guess I would have to say a feeling of total pressure, pushing me in a direction that was totally wrong. The consideration was not given to the type of job or experience that I had, in general it was a case of you can do anything that we tell you to do, which I just found demoralising, disheartening*

We hope the following framework and analysis will point to changes that can be made to ensure this description is less applicable in the future.

Poor communication

Claimant 163's comments capture what a number of claimants expressed regarding perceived difficulties contacting people, getting responses back from left messages and general coordination saying:

> *Because I get, I'm getting bounced around, whenever I try to find out who's doing what and who's actually looking after the case for me they say we'll have to get back in touch with you again because we don't really know.*

And later in the interview

> *Again, it's the communication, they have no idea what the left hand is doing and that's stupid, it really is.*

Interestingly – a number of claimants who felt they had had reasonable services from ACC nevertheless felt that communication was a major issue as demonstrated by Claimant 502 stating:

> *Communication was really the worst thing… I mean I didn't have a bad time – they were pretty good but I never knew who to ring – felt I did a lot on my own.*

Further, poor communication was noted by Claimant 406's wife who said:

> *There was just a real lack of clear communication from ACC about what we should expect or what was around the corner.*

Finally, the experience of ACC and its communication is linked to ongoing perceptions of ACC and undoubtedly what ex-claimants say about ACC to their friends and families. For instance, Claimant 502 stated

> *Its really just the communication - follow up - a phone call is nothing - just see the person is coping rather than 'you are off ACC - we don't know you any more'. Once I stopped ACC – I would have really liked someone to ring me up and see if there is anything you need… I mean I've known of other people who get chairs and things that fits their problem - but because I was off ACC, I'm not going to ring them up and ask them because they'll probably say no.*

Communication issues between ACC and providers was noted by a number of claimants for instance Claimant 134 said

> *CLAIMANT: Its just that to get it to continue has been just an uphill battle and the last specialist that ACC sent me to he turned around, I got the report back from him and he said that in two or three months after further physio I'd be able to return to work, so I rang him up and I said the thing that you're sending the case manager, can you be quite specific on what exercises you think I should need to do because there's no use the physio asking me and he said no no I'll do that, and I said and you reckon I could go back to work in three months and he goes yeah, you should be fine and I said should there be any restrictions on what I do and you know what he said to me, one TV is the same as the next.*
> *INTERVIEWER: He said that?*
> *CLAIMANT: And I said what have TV's got to do with it? And he said well you're a TV repairer aren't you? And I said know I'm a builder. And he goes you're joking and again I said no, and he goes oh my god, well how come they told me you repair TV's and I said I'm damned if I know! And he goes we'll I'll redo my report and furnish it to ACC and that was way back. So I don't know how in the hell they thought I was a TV repairman!*

Distrustful relationship

The importance of a good working relationship between the claimant and other parties involved in vocational rehabilitation was captured in this comment from Claimant 94 who said:

> *I don't know of anything that needed changing in my case. I think because I had such a good working relationship with the case manager and the GP and I think probably the understanding of the case manager is very important*

Many claimants expressed a sense that they were not believed or trusted and that they also found it difficult to trust ACC. For instance, Claimant 163 stated:

> *And that was one other assumption that ACC made, that I was careless… they were putting the blame on me. You can do nothing wrong and still have an*

> *accident, that is the fact, so for them to turn around and make an assumption like that is degrading, demeaning, and then damn right bloody rude. And there are also the odd time that I have actually been told oh but you're faking no..*

Likewise, according to claimant 311:

> *I've been to every specialist they've ever invented, through the ACC system they've oh well you know we don't believe this person, no we don't believe this person, so now you've got to go to this person, so and it was getting to the point where I was really sick of it..*

Many claimants expressed that they felt their credibility was questioned such as Claimant 272 who stated:

> *I think case managers get a bit blasé really – all sorts of reasons but… I just don't think they believed me. That was frustrating beyond belief*

This experience was reiterated by Claimant 555:

> *I felt they just kept on pushing me to do more hours, and I said I'd go to any specialist they wanted to just to you know I'm not here to rip the system off… it's like to me it should have been either work asking for the work assessment or you know they should have been dealing with ACC saying you know hey this guy's ripping us off, we're not happy with what's going on, get someone out. I felt that there was so much pressure there that bugger it I'll organise it myself, and I'll get the lady in and she was great.*

Claimant 28's distrust of ACC was captured in the following comment:

> *I would hate to think how someone who wasn't strong enough would get on. They just disappear into the bloody woodwork and they'd suffer the, it cost me a bloody fortune. It cost me megabucks, I mean that, and I feel so bloody bitter about it. And that's not going to go away.*

Whilst some claimants may attempt to 'use' the system, many of the interviewees indicated that their early relationship with ACC indicated that they were 'assumed to be guilty' from the outset.

Feeling demeaned/disregarded

Within the other barriers, claimants often used words about finding the processes they were involved with distressing and demeaning. This experience occurred in dealing with ACC, health professionals, vocational providers and indeed in the workplace for some claimants on return to light duties or after a period away from the workplace. Claimant 297 stated:

> *To be honest I felt like a bit of scum. I have to say, be careful what I'm saying, how do I word it? I felt like one of those that don't ever want to work but are just there to get the money out of the system and it hurt greatly that I had to swallow my dignity to even originally get ACC, I didn't ask for it, they gave it*

to me, and it was really hard to go through this demeaning process where I felt as though there was no trust on their part that I wasn't having them on you know and I felt, I think I said several times to my case manager I get the feeling that all you are interested in is pushing me back to work whether I'm fit or ready for it.

Imbalance of power

It seemed that one factor influencing the distrustful relationship was a perception of being out of control when there was an imbalance of power in making choices. To some degree power does indeed rest with the organisation that has responsibility, such as ACC. However, the perception of imbalance in power was associated with the claimant's sense of involvement in building relationships and feeling involved in decisions and indeed, maintaining control of their lives. For example Claimant 67 said in a very matter of fact way:

I followed the books because xxx my case worker threatened me with all sorts of dire results and I was good

And whilst some claimants seem to accept such imbalance, others found it frustrating and difficult for example Claimant 28 reports:

Well it is actually sort of tied up, because it all, everything sort of pushed me away from doing my own thing, and ACC are sort of been well this is what we want you to do and this is what you are going to do.

Claimant 163's statement reflected a similar perspective:

They were literally trying to run my life, and I don't take kindly to that, I never have.

And in some ways indicating that the real purpose was lost:

Because that's what they are there for, they're not there just to order you. They have to find out themselves what the client wants, I am a client and need to get back to work

Disconnection between claimant perspective/need, assessment and intervention

For claimant centeredness to feature in the process, claimant buy-in and understanding of why things are happening is clearly important. Many examples in the interview transcripts seemed to indicate that claimants really had very little grasp of why assessments may have been proposed or repeated or why there may have been repeated assessments that seemed not to lead on to any intervention or action. For instance, Claimant 440 states:

There's been a heck of a delay time waiting for the third, there's been a lot of expense, I just returned from Auckland last Friday from the third opinion

which I don't think was totally necessary because it came to the same conclusion what I've known since I had my injury well accident

On a number of occasions, it was possible to see that a rationale for an assessment or action did in fact exist (on case note review). However, claimants did not always understand the relevance of that assessment or action. For example Claimant 190 stated:

All she wanted was me to write down what pain levels every day, how I felt, how I felt, I mean some days I feel oh God I could run a marathon, next day give me a wheelchair. But that's all she was interested in, then she would do her little assessment of that and it was like well how is that helping me, it's not helping.

In this case, it does seem the assessment may have been warranted and yet the claimant was clearly unable to make the connection between the assessment action (daily recording of pain levels and activity) and any possible value to him (stepwise progression of activity).

A particular issue for some people was the contracted interventions appearing to have little to do with their situation. For example Claimant 311 reported:

The thing is it's only for a short period of time, like even with physio it's only for 12 weeks, or 8 weeks or whatever and even with training it's just for, with the computer course I did that was only 8 weeks, do you know what I mean everything is like 8 weeks and because I'm a what I call a long term ACC person, should it not be case by case?

For other claimants there was a perception that they were 'not worth' intervening with in the areas that they perceived as most important. For instance Claimant 351 (on claim for 13 to 26 weeks) stated:

CLAIMANT: They've done nothing., lots of questions and then just told to go find a job, they haven't helped me to go to any other job or anything. Didn't try to educate me or anything, I'm a losing response or something they said to me one time.

INTERVIEWER: Losing response?

CLAIMANT: Wasn't worth the money to educate me.

Not understanding pain and functional limits

A lack of understanding the assessment and rehabilitation process was particularly apparent for people with pain conditions with 'cure' or 'eradication' of pain becoming an all encompassing goal. Given the complexity of pain this is perhaps unsurprising. However, helping people understand this complexity requires a relationship of trust and extremely good communication. Claimant 167 stated:

> *I'm not looking for sympathy or anything like that, I'm just looking for a way of getting rid of the pain. That's all there is to it.*

Such comments reveals that eliminating pain remains the claimants goal despite clear indications from other people (health professionals and ACC) that ongoing pain was likely to be experienced:

> *you know it's easy for someone to say oh just live with it, but unless they are the ones suffering from it, it's a totally different story then, but then if it was he suffering from the pain then I'm sure he'd be seeking out every possible avenue*

Lack of appropriate early intervention / delays.

Given that evidence would suggest re-engagement with work as early as possible after injury is most likely to result in good outcome, it was concerning that for many people there appeared a lack of early intervention. There is indeed a tension here as many claimants reported feeling 'pushed' back too early (see further discussion on Expectations and Stakeholder involvement. Participant 190 (working for an accredited employer and managed by a Third Party Administrator) stated:

> *But the whole thing was xxxx weren't going to act on any of the claim until I'd been to the specialist, got the specialist report…*

And

> *Well they got the specialist report and then my case manager sort of disappeared, like they got the report in the beginning of December and it wasn't until February that they actually acted upon the report.*

Delays are inevitable at times but these findings echo the case note review findings indicating that for many people a substantial amount of time passes before steps towards RTW are initiated. Such delays increase the likelihood that a claimant may adapt to being off work because not to do so, is distressing. Indeed the claimant above noted that this delay triggered a depressive episode with suicidal ideation as he felt that there was no way out.

A number of claimants talked about being 'forced' to go back to work too soon or 'forced' into an intervention that seemed mistimed. For instance Claimant 134's recollection was that the first intervention he got was help with preparation of his CV saying:

> *Well, the first thing that happened to me I was asked to do a CV … the xxxx said to me was the biggest decision I had to make was the colour of it, the cover, and I think it was too soon after having an accident when I was still unable to do anything*

> *I've just got to a point where I've given up on the whole thing but I think what ACC should have done is started with – well what do you need to make yourself comfortable. Ok, they did that pretty well as far as organising a back support chair to sit in. But - then get the physio happening right, and then when you're sort of able to stand up and do something then decide where you go from there I think. Like they seem to have had it in the wrong order, and like they look at my report now and it goes ok cant stand up cant sit down for too long, um tires quickly, ok cant do nothing, It's depressing.*

Processes seeming over complex or conducted 'just for process sake'.

One of the features of the case note review and indeed the stakeholder interviews was a sense that at times the processes within ACC (documentation, approaches to assessment and indeed interventions) have become somewhat divorced from the outcomes they were intended to serve or produce. Claimants too perceived this with a number of interviews indicating frustration and confusion over the processes. For example according to Claimant 167:

> *All the paperwork they send you, extremely confusing. Because it's not, you don't just get it once, in two weeks time they change the rate because of some reason, and then they send the whole lot to you again, and you don't just get it all in one envelope, no they send it in about five envelopes*

And

> *Yeah the paperwork, I just thought oh it's one of those forms and one of those and one of those, you staple those together, bang them in the folder, I don't know what it means but look for the end figure, oh that's what I'm getting a week or a fortnight. And I don't know why I'm getting that because it changes and I don't know how many times it changed over three months.*

Indeed, sometimes these processes were perceived to impede maintenance of the work role.

Process actually seeming to prevent maintenance.

Maintaining someone in their pre-injury employment wherever possible is clearly a key goal of vocational rehabilitation. However, similarly to comments noted in the expert review of IOA and IMA, a number of claimants perceived that ACC involvement had reduced their opportunity to maintain their original employment position. For example Claimant 163 states:

> *'Well the main barrier is, well ACC actually made sure I wouldn't go back to the same job, I'm very very annoyed about that*

going on to say

> *they just went straight in behind and they did a deal that they would not allow me to go back to that particular company.*

Claimant 44 particularly identified frustrations with the IOA/IMA process (carried out at 6 weeks in her case) by saying:

> *You know I had to go I think it was to one assessor who was going through what other jobs could you do, and I thought well I don't really need this because I don't want to do other jobs*
>
> *Yeah it was, yeah, I started thinking well maybe I can't go back to work if we're going through this.*
>
> *I felt like I was hitting my head against a brick wall. It was like boy here's something we could do or here's something you could do and it's like, nothing's happening.*

Facilitators

As one might expect, the factors reported by claimants that would facilitate vocational rehabilitation were largely a mirror image of the barriers identified above. Claimants identified specific features that either made or they felt would have made a difference to them. Many of these facilitators rested upon the nature of the 'human' aspects of connection between the claimant and ACC representative or heath professional.

Being treated like a person

A central feature of case management for non serious injury claimants who may nevertheless receive compensation for longer periods of time, is about managing difficult situations. Examples of this include: problems in maintaining original work role; coping with pain and the fear that this may well be with them for life; and the difficult processes of Vocational Independence assessment. Accordingly, it is likely that the relationship between the case manager and claimant is going to be crucial in influencing claimants' internalised response to that situation and indeed their resultant actions. Claimant 498 stated:

> *My hope would be that the way that everything is sort of run and that improves a lot and that it's sort of more focussed on the person that's got the injury rather than on the costs or you know the time and that sort of thing*

However, as noted in the section above about feeling demeaned or disregarded, many people felt that they were anything but a person within the process. For example, Claimant 297 reported:

> *INTERVIEWER: So in terms of feeling valued, your skills and contribution that you already had, did that happen at all?*
>
> *CLAIMANT: No they were non existent, they were ignored, yeah. Totally weren't they. You know my family's gone to hell and back with it too because they've seen what's been going on, from being a very independent, strong*

person I've had to cope with all of this, but I've also had to cope with the fact that the things that ACC have put me through have made me feel totally useless. It's just yeah I think it's the attitude, you're a number more than a person.

Claimant 190 suggests that humanity and people skills are crucial to good case management for return to work. Having stated that he had had 7 or 8 case managers, some of whom were great, the interviewer asked:

INTERVIEWER: And what made some of these case managers really good?

CLAIMANT: Their people skills... their listening skills. I mean, and it's not just them, it's also the person that has to see them, like myself, makes you want to be straight up and honest, no problem.

And about another case manager he stated:

I had to ask and I had to go and see her, it was like none of her coming to see how I was or anything like that, it was like we'll discuss that when we have our meetings.

Comments such as this are particularly interesting as they indicate that not only were these skills and human-ness valued by the claimant but they do indeed have potential to contribute to the claimant's response. In this instance, the claimant responded to the case manager by being 'straight up and honest, no problem'.

One claimant (67) captured the importance of this two way relationship by saying:

Well I was treated like a human being, I wasn't spoken down to, but I think you've also got to have the right attitude, if you get the gist of what I mean, I didn't expect miracles because after the first op the specialist said you're going to have to take things easy because your shoulders weakened now and ACC didn't, well I didn't earn very much money, but they didn't pay me very much and what I got on the pension that sort of flecked out the rest to, so everything, they just did the best they could and ell that's all you can do.

As long as they treat them like human beings, you know. Some people find civility a little bit hard to find, and I mean that on both sides, you get a shitty case worker, and that will put your hackles up, but also you get arrogant people that come in demanding this demanding that and demanding something else, and you don't get anywhere. I think I was fortunate through being a carer, you've got to learn patience with the oldies and with the youngies and with whoever you're looking after, but you've also got to learn to be kind and polite, and also to take other peoples feelings into consideration

Claimant 311 also saw a difference in how case managers treated her as a 'case' or as a human being:

Ah no I started with a guy when I came back to xxx and I can't actually remember his name but anyway, he's since moved on and then I got yyy and she's just amazing, she's a great case manager, she puts herself in my

> *situation you know without, you know she knows what's wrong, you know she knows the job basically.*

The claimant continued

> *…and I had a case manager in xxx, she was just a right bitch and I'm being honest. To the point that she was going by the book, she said the way that ACC works is that if you are on ACC a doctor says you can work 20 hours a week, we give you three months, see you later. And there was no compassion, human feeling within it if that makes sense.*

Finally, Claimant 502 stated:

> *Knowing that you are a number to them- its pretty hard to bare your soul to them.*

It should not be surprising that claimants wish to be treated as people rather than as a 'case' or in some situations, less than human as noted above. However, throughout the questionnaires, the interviews, the case note review and the stakeholder discussions, this topic and related areas were brought up repeatedly as noted above (in the Barriers section). The next two Facilitators indicate two specific domains for change.

Being listened to

The following comments could in many ways fit into the above category. However, we have afforded it a sub-heading because of its frequency (almost unanimous agreement among claimants) and its significant impact upon the claimants. According to Claimant 190:

> *But some of them, when they started actually listening to what was actually going on that I had to suggest, it was felt like yeah well we are getting somewhere.*

Likewise claimant 311 stated:

> *Well the first thing they should do is try listening to me, like they listened to all these other people, you know how they send you to a specialists and then more specialists, and they send all this paperwork… but none of it is actually about what's going on, do you know what I mean?*

Claimant 502 (who described a mixed experience of ACC) clearly perceived one of the five case managers she had in 12 months as *listening* and that making a difference:

> *One case manager was brilliant – she listened to everything I said – and worked with people at my work.*

Feeling as if one has been listened to appeared vitally important to all claimants.

Considering the person and their context

The other area of interest is that a number of claimants talked about the lack of (or in some cases the helpful aspect of) having the 'whole person' considered as opposed to just their injury.

> *The most major one is that ACC pull their head out of the sand and actually look at the person themselves, the whole person. Their whole experience and ask them where they want to go back to.*

And Claimant 311 stated:

> *I said no hang on a minute that's not the point, you've got not just the injury, you've got the fact that my leg won't work properly any more, the fact that it affects my whole life with my husband and myself as in our relationship, and it also affects my relationship with my eight year old son. But when they are doing all these assessments for payout and for you know even my benefit you know your 80% of whatever, none of that comes into it. It only comes down to basic, OK she broke her leg, oh yeah it might take six months to heal, right we'll pay her this much for six months. Do you know what I mean, they're not taking into the whole picture, the big picture. And that I am only thirty three sort of thing and that well what am I going to do with the rest of my life?*

The perception ACC is only interested in 'the injury' is somewhat at odds with the other frequently stated perception that ACC is only interested in 'costs' or 'getting me off the scheme'. However, it does point to one factor that seems to influence trust and working towards a shared outcome. Perhaps it is difficult for claimants to work towards these goals if they perceive that the injury's impact on their broader lives are of no concern to the people working with them, in particular ACC or the related health professionals. Whilst it is clearly reasonable to have a limit on formalised assessment, getting 'buy in' from claimants during the difficult vocational rehabilitation process requires that claimants trust ACC employees and health professionals and that claimants feel validated. A central component of a successful relationship in this context is that claimants feel their priorities are heard and responded to.

Shared plans and discussions between all team members

This is a section of the interview transcripts which remain very brief as so few claimants had meetings where they felt the relevant members of the team met together. However – a number of claimants specifically commented about a lack of teamwork for example Claimant 16 stated:

> *Even if the case manager could just write letters to GP, specialist, physio, and me discussing what could be done to help and keeping everyone involved – really there was no teamwork at all and I relied on my GP in the end and the Physio at the gym.*

In another example, Claimant 308's case manager convened a meeting due to difficulties in returning this claimant to her original position:

> *Well there was a meeting with the case manager, my employer and an advocate (who didn't get a word in). He [employer] just kept saying it wasn't because I wasn't doing the job, it was a health issue… Yes, he kept saying it wasn't a performance issue, it was a health issue, and unless I could basically say after the operation that I could return to work full time basically immediately, that I could no longer, you know he could no longer see how I could carry on with my management position. …. Well, when we had the next conversation it was just him and I, and because I was so upset at the time you don't really think, I was more worried at the time about losing my job, and I wasn't probably in the frame of mind to think straight if you know what I'm saying, I think because you sort of get all stressed out, you don't really think properly at the time and, or clearly is the word I suppose, and yeah, and I, he, I don't know how [Case Manager name] got to know actually about my position unless, of course she rang him I don't know because I know they ring each other.*

Whilst outcome data suggested this claimant had a successful RTW, there was clearly a mismatch between the employers focus on outcome and the claimant maintaining their position. Indeed the ongoing consequences of her injury subsequently led to her losing the management role (found on followup). She went onto say that she perceived a lack of open communication and meetings that were not 'team' discussions but arguments. She perceived that this dynamic at least partly contributed to the loss of her senior position stating:

> *I think with you know, if they had more, they were more proactive with your actual employer, maybe this sort of thing that happened wouldn't have happened. Because what I was so mad about with my employer was he said that I couldn't continue to do my position, and then he said that it wasn't a performance issue… isn't that what rehabilitation was about… I really think he had it in for the fact that they hadn't been in communication…*

A number of claimants described a sense that their case manager was in fact a barrier to the potential for teamwork. Claimant 297 stated:

> *When I had finished the pain clinic then ACC case manager said oh good now you've finished that you'll be able to got back to work, and the pain clinic had suggested that we had a meeting at the pain clinic between the case manager, them and myself, and my case manager refused, she said she would have a meeting with me in her office, and that was all and I said well I don't think*

that's going to gain anything. I knew what was going to happen, I wouldn't let myself be put in that position.

And Claimant 555 stated that he felt the lack of teamwork had to be managed by him:

But yeah, I just felt their communication between work and ACC wasn't happening, you know it had obviously fallen apart there for me to have to take the steps to do it. I think the lady concerned actually felt pressure from my employer as well and she was just well we've got to get you back you know and hey that's all good but we can't do it at the moment so… she just should of stood her ground or she should have said OK look if you're not happy with what he's doing I'll get him assessed, but I've basically did it myself, I rang her and said send someone out, I'm not going through this any more.

Adequate skill and training of case managers and assessors

As noted above, a number of claimants referred to the 'people' skills of the case managers who they had found helpful. Along with those people skills, professionalism and accountability was also mentioned. According to Claimant 498:

The original case manager when it was under short claims, she was really good, she was really supportive and helpful with sort of everything that I asked her about and that. When I got put on to I guess it would be long claims I think, the case manager that I got to be honest as far as I'm concerned was absolutely useless… as far as I was concerned she wasn't sort of willing to help me at all, her main goal was just to get me back to work soon and off the ACC payroll. But the case manager that I got towards the end, he was quite good, I didn't have any problems with him, he was, he sort of you know was straight up, told me everything that I needed to know

Claimant 311 indicated that it was not only ACC case managers whose training might require some rethinking by stating that the clinicians and other providers involved in assessments also need to be 'professional':

No and the other thing is that ACC shouldn't just because a doctor has got an MD in blah blah blah, and but he might be old school, you know what I mean, and they should believe specialists that have been doing these, you know going out to these like seminars in America and you know getting off their backsides and trying to learn more, and not just learning old school. If that makes sense?

And Claimant 167 referred to a limited service that appeared to lack a rehabilitation focus from his GP says:

And in a sense I feel disappointment with her, she doesn't, she's very good at prescribing but she's not very good at finding causes or solutions.

Claimant 190 refers to the perceived professionalism in his experience in a rather 'matter of fact' way that almost indicates nothing more was or would be expected stating:

> *Well, apart from the Occupational Nurse and my not so great case manager, and management at work and certain lack of understanding from other workers, I think everything went reasonably well. A lot of, [TPA] were like surprised that I got off my own back, and started doing a gym programme, started helping myself, where a lot of people just wouldn't, as far as I'm aware. So they basically like left me to it.*

The final group of factors have been called 'Solutions' as whilst also being 'facilitators', they seemed to highlight specific actions that were required to facilitate vocational rehabilitation in line with the goals and intent of the Act.

A focus on rehabilitation

Very few of the interviewees actually used the word 'rehabilitation' or 'rehab' in their interviews whilst words like injury, recovery and treatment occur repeatedly. However, a few participants did refer to rehabilitation including Claimant 311 where the following extract captures a number of crucial issues relating to a) a definition of 'rehabilitation', b) partnership, and c) expectations:

> *Is it not then ACC's responsibility, along with mine of course[4], to retrain me in something else that I can do or help me learn a new skill[1], so I can get a job or it takes me somewhere[2] … look if I can only work 15 hours a week for example[3], is it not their responsibility to help me get there[4]*

Embedded in this comment is a quite sophisticated reflection on some important components in rehabilitation whereby educational and problems solving techniques[1] are used to enable someone to achieve a desired outcome[2] and that revised outcomes are sometimes necessary with a change in the person's condition and circumstances – ie the whole of person context on which rehabilitation depends[3] and that help is required in making this adjustment[4]. Statements elsewhere in this interview and in other claimant interviews indicate this adjustment is for many complex, difficult, significantly challenging, and distressing. This claimant's comments also indicate she did not perceive such a focus in her involvement with ACC. She clearly identifies that she has a role in this process[4], and that without partnership between her and the parties involved in her rehabilitation, a good outcome is unlikely. Thirdly – she has clear expectations of ACC's role in rehabilitation and in facilitating her progress (see below for discussion about refocusing role and training of case managers).

A further comment from Claimant 163 comments captures why so few references to rehabilitation are made and also why a shift towards more active rehabilitative management of claimants is warranted:

> *But… they just sort of, they weren't really worried about rehabilitation- that was the whole thing, they had no contemplation of actually trying to help someone rehabilitate.*

Refocusing the role and training for case managers

In the upcoming discussion of stakeholder views, the role and training needs of case managers was a frequent topic. The predominant focus within stakeholder discussions was on workload, frequently the size of case load and the appropriateness of that. Within claimant interviews, it is clear from the above discussion of barriers and facilitators that case managers have a key role in claimants' experiences of vocational rehabilitation. A number of specific extracts highlight this seeming 'business' of case managers. Claimant 498 states:

> *Yeah, getting hold of that case manager was quite hard as well, I can understand that they've obviously got x amount of caseloads that they've gotta deal with on a daily basis so I can understand her being busy to a point, but yeah, I mean there was time I had to wait sort of a week to two weeks before I heard anything back from her and that sort of thing. Yeah.*

Whilst one might interpret this to mean that claimants see the solution as being 'more of the same' or more case managers, it may also be that a refocussing of the role is required. Many claimants, and indeed case managers we talked with in the stakeholder groups/interviews, identify the role as largely reactive, with an over-emphasis on procedural aspects of the role, frequently to do with 'claims' management and/or processing documentation associated with the case. For example, many of the claimants focussed on quite tangible things within the role such as entitlement and indeed provision of equipment. For instance, when asked about the key aspects of his experience, Claimant 229 said:

> *Well I was quite happy with everything actually, the woman came round, actually paid for a for a new pair of working boots for me too, I think I paid seventy, I think they paid the rest.*

Further, many claimants perceived the financial aspects of their case to be the driver of their case manager's behaviour. As an example, Claimant 498 said:

> *Yeah, and yeah I brought that one up with her but she basically sort of shrugged that off and said that wasn't their problem as such, you know that was up to me and if I wanted to change jobs it was all on me. Yeah they weren't too concerned about what I was doing as a job apart from the fact that they wanted me back at work and off their payroll.*

Whilst the scheme needs to run with financial efficiency and, while entitlements and provision of equipment are important, arguably for effective 'rehabilitation' to occur

(which one would suggest should lead to improvement in the Global Domain scores in the case note review), a shift in skill-set development and performance within the role may be warranted.

Clarifying the role of compensation

Many claimant interviews included comprehensive reference to 'benefits', 'payment' and 'compensation' when discussing the financial aspects of their claim and entitlement. Within these discussions, there seemed to be significant confusion about the nature of compensation and its purpose. The following interchange between Claimant 28 and his partner demonstrates this phenomena:

> *CLAIMANT: It cost me a bloody fortune. It cost me megabucks, I mean that, and I feel so bloody bitter about it. And that's not going to go away. Totally un-compensated you know.*
>
> *PARTNER: He was never compensated, all he got was part of his wages.*
>
> *CLAIMANT: Bloody crap.*

Claimant 311 perceived workers compensation to be a 'benefit' and appeared to indicate it should therefore be measured against her degree of suffering rather than her prior income:

> *I said no hang on a minute that's not the point, you've got not just the injury, you've got the fact that my leg won't work properly any more, the fact that it affects my whole life with my husband and myself as in our relationship, and it also affects my relationship with my eight year old son. But when they are doing all these assessments for payout and for you know even my benefit you know your 80% of whatever, none of that comes into it.*

One claimant (167) whose compensation was based upon a minimum wage salary indicated the amount was insufficient for his family to manage and he had therefore returned to work prematurely and with significant and persistent difficulty. He subsequently suggested that perhaps a sliding scale of % compensation according to salary may be more appropriate if trying to maintain someone's involvement in rehabilitation. However, of particular note in this domain is that he seemed to regard compensation as only being paid to some claimants rather than being a universal entitlement:

> *I really do think that if you go on ACC it should cover your whole wages. Maybe people who are on very high salaries, well they wouldn't get ACC would they?*

These discussions reveal a degree of confusion about the purpose of compensation persisting even when people have been claimants for substantial periods of time and

arguably, should 'know the system'. This has particular relevance for expectation setting amongst claimants early on and even in public education about ACC. At the outset of this study, the research team were intrigued that people spoke of 'being paid' by ACC. However, it may be that consistency over terminology (even using the term 'being paid') would help promote a shared notion about the purpose of such payment and claimant responsibility associated with receiving that payment.

Balance medical, social and psychological perspectives on RTW

The final theme of the claimant interview data further emphasises case note review and questionnaire findings whereby a biomedical/biomechanical approach is perceived to dominate ACC's current approach to vocational rehabilitation. Clearly, good medical assessment of impairment is essential in the early management of injury and when 'pathology' remains a key contributor to RTW. However, nearly all interviews (including those with claimants where case note review and questionnaire data indicated 'good' vocational rehabilitation in terms of the aims and intent of the Act) revealed a lack of focus on the social and psychological needs of claimants. Arguably, it is a reasonably normal response to injury leading to a period of time off work to experience some sense of loss, distress or need to adjust to changed circumstances. The importance of these factors is captured by Claimant 94 who says:

> *If you've got positive psychological attitude towards these things is makes things easier. I didn't really have a problem going back to work. I still don't do work to the extent I used to, I either use mechanical means or find somebody else to do the job for me.*

However, the interviews reveal that many claimants perceived such factors to be poorly considered. For example Claimant 163 states

> *….a lot of the people are not trained well, if they were trained well then they'd actually be able to sit down with people and actually go though it and find out what A caused the accident B were there other factors that we have to look at, like with in my case yes there are other factors they have to look at,*

The claimant later reported

> *And then it was more mental than physical, because you injure yourself badly and you have got one hell of a job just trying to get over the mental side of things, and then because I was constantly being told no you can't to this you can't so this you can't do that.*

One claimant (311) who received a copy of her assessment (in some ways indicating 'good' communication) reflected on the feelings that this provoked:

> *But the problem was when I finally got the final report from xxx, stating in black and white this is her problem, it can't be fixed this is going to be for the rest of her life, one feeling was relief, two was oh my god where do I go from here.*

Claimant 498 was one of a number who spoke of their emotions and response to injury and their rehabilitation. It appears that *how* they were treated exacerbated those feelings and further, put them off using ACC saying:

> *Yeah, it's almost got that snowball feeling to it where you know one thing goes wrong and all of a sudden everything's just you know yeah, I did get quite upset over that time, and yeah but as time went on sort of thing it wasn't so much that I was worried about not getting back to the job it was about finding a job that I could do and basically getting off the system, because I mean I didn't want to be on ACC and the treatment that I received made me even less sort of inclined to want to stick with them sort of thing.*

Going on to say

> *I felt quite depressed actually, but I sort of attribute that more to that case manager than anything else. Yeah like I was upset about the fact that yeah I wasn't working, I mean the first thing, the first though that went through my mind when I did the injury was I'm only 20 years old and I'll never work again…*

Summary of claimant interviews

The claimants interviewed in this part of the study had been chosen to represent different age groups, genders and also varying experiences of vocational rehabilitation according to the case note review. A number of claimants' case note review indicated 'good' quality vocational rehabilitation and, a number spoke positively of the difference their case manager made and their treatment. However, many of these also highlighted issues of concern. Our analyses has focused on exploring how claimants' stories have highlighted barriers and facilitators to vocational rehabilitation, their return to work process and indeed, their involvement in their rehabilitation (See Figure 10 for a summary of these). Further – some key 'solutions' emerged from their stories and contribute to the recommendations within this report.

Stakeholder views

In addition to the core data set (claimant data) a range of vocational rehabilitation stakeholders were consulted to provide a context for discussing findings and testing out recommendations. In total over 80 people were involved in these discussions based on 11 individual interviews and eight focus groups. Stakeholders included a) internal representation of ACC: corporate staff and network staff (case managers and branch managers, team leaders, remote contact centre staff) and b) external stakeholders (including Third Party Administrators, accredited employers, other employers, lawyers, vocational rehabilitation providers, physiotherapists, occupational therapists, and general practitioners). Stakeholders were located throughout New Zealand. As noted in the methods, data were tape recorded and transcribed verbatim other than for one discussion where the participant/s preferred that the discussion not be recorded.

Rather than a full analysis, a brief summary of key themes is highlighted below for the following reasons;

1. the key focus of this research is on claimants and their experience of / outcome from vocational rehabilitation
2. a number of stakeholder sessions were unable to be scheduled prior to the report deadline meaning analysis is incomplete
3. there was remarkable consensus between the majority of internal and external stakeholders on the key barriers and potential facilitators to improved processes and outcomes. There was also considerable consensus with the claimants' claimant perspectives and so we attempt here to avoid repetition of the barriers and facilitators already clearly identified.

Views of stakeholders:

Nearly all stakeholders agreed that significant improvement in many aspects of vocational rehabilitation had occurred in the last ten years with providers particularly noting improvements since the middle of 2006 when the contracts were changed to allow what they saw as greater 'claimant centeredness' and 'whole of person care/management'.

Despite these improvements, significant changes in provision were felt to be required if vocational rehabilitation were to be provided in ways that meet the aims and intent of the Act as noted below. A number of extracts are not attributed to a specific member of the stakeholder group in the case this would risk identification of the contributor.

Processes, Key Performance Indicators (KPIs) and Leadership

Whilst 'standardising processes' was identified as an important aspect of trying to improve the quality of ACC services, there were many instances when stakeholders reported these processes had become somewhat divorced from the 'intent and purpose' of the Act and instead, become an 'end in themselves'. This was particularly evident when discussing Individual Rehabilitation Plans (IRP) and assessments such as IOA/IMA.

Individual rehabilitation plans (IRP): One case manager commented upon timeframes for return of the signed IRP:

> *Every rehab plan we send has that in place, and the thing is most people don't read and don't discuss and quite often they sign and return or else we do just deem them, so not discussion, and a rehab plan, I think even in the act it goes on about you know in consultation with your general practitioner and it's not supposed to just be a mailing out of a plan, but because the KPI is based on it, then that is what you're going to…… you can set a KPI can you get i. Yes you can you know, there are KPIs about exits, I can get exits, they might not be right, but I could get them you know they might not be the best for the person so it's not creating an environment then to say you know like your KPI isn't indicating you have provided the best rehabilitation*

Another reported:

> *I personally don't believe IRPs should be signed up without discussion with the person themselves, but interventions need to be well - you need to sit down and go through them and discuss them, then they need to have the opportunity to go and discuss them with their GP, and then - send out the IRP but …. I wouldn't type one out and send it out and say please sign. They only time I've done anything like that is if the intervention has stayed the same but the outcome to be achieved date, again that's a KPI thing, we're not allowed to have expired, so if things haven't been achieved on the IRP you need to extend that date out, and so that's why lots of those IRPs go out, and payments say it all the time, it's got the same things on it, and it has, but for bureaucracy we've now just sent a new one out for longer extension date and you know that sort of thing I say about how busy case managers and things are, that lots of our time is wasted on things like that*

And

> *Yeah but 80% of claims, look at the stats, 80% of claims get better in three weeks. So who needs a rehab plan for three weeks. ACC have thirteen weeks to make their mind up before one is legally required. If you're in the partnership program what is it, fourteen days, one week two days, so I think rehab plan needs to be defined and probably explained better, because the ones the TPA's doing, are doing it to pass an audit.*
>
> *Yeah I mean I guess it depends on um, yeah, KPIs are a difficult thing, I mean we had KPIs round individual rehab plans, they're not actually about the quality of the individual rehab plan, they're about have you got one and is it signed on file, so just the connotation that it has to be signed on file and you've got to have them there all the time takes away from the fact that individual rehab plans are supposed to be negotiated, discussed and agreed to, and you can't tell me that you can have 100 percent of your people happy with their individual rehab plans as you've written them, and have that on file, and people do but that's not because they're, it's not because they're providing good rehab or doing anything great for the claimant, they can have you know, we can suspend, decline entitlements, we have lots of power to get those things that we need for our KPI*

<u>Regarding vocational rehabilitation generally:</u> A number of people reiterated the value of work and a 'stay at work' approach where ever possible being key, but not prioritise for example:

> *And I said, for all sorts of medical reasons, people need to be in work, and our whole society would benefit and we would have much more money to go round if they rehabbed properly and we all owned the problem, rather than shifting it. But they just wanted it off their books, and we don't care that they'll go onto the invalid benefit and then stay there and have all the health things that go with unemployment.*

<u>*Regarding assessments*</u>:

> *it's like IOA, IMA within 6 weeks that's a KPI for the branches, so it's not how good it your IOA because you don't want to look at that because if you have to have it repeated you're not going to get it in within your 6 week timeframe. Initial medical assessment, it's not who is the best doctor to send this person to, it's who can I get within this timeframe, so it's taking away the good of what could be a good assessment by attracting KPIs that require you not to provide the best things, so it's the same with the rehab it's the same with the assessments, it's you know it's not always about getting the best person for the job, you know having the best programme, it's just having the programme getting it done*

and the in appropriateness of ill timed assessments just to be in keeping with a KPI:

> *Rehabilitation was something that you inflicted or imposed on somebody, and the IOA is a classic example of that. I can remember talking to a gentleman who had a particular injury, had surgery for it, was going to be able to return*

> *to what he was doing prior within a certain timeframe, but, on no uncertain terms was I to delay his occupational assessment, I had to do that at point x. The reason for that is that if you go through a process and then you get an exit before week 52 in effect.*

Although some branch staff talked about the KPIs not influencing the day to day relationships and communications with claimants, the data would suggest that in fact otherwise. Current KPIs appear to impact on both the vocational rehabilitation process and outcome negatively and this is also evidenced by the case note review and questionnaire data eg.

> *The second thing would be to put more focus on looking at upskilling people if there aren't suitable job options for them, and also putting a greater emphasis on people returning to the workforce in any capacity it doesn't, like just because somebody's not working full time doesn't mean it's not a good outcome. So I think there needs to be some emphasis on there as well on that, but they probably need to be KPI because that's how people respond because people say well that's what the corporations sees as important then that's where I'll focus my effort.*

A comment from one ACC branch staff member suggested variability across the network in KPI's driving behaviour saying:

> *I'd like to think that one of the things that might come out of the research is that it could note that if you are going to go as far as we did, which was give people an absolute directive, about something which is important in a process, but which needs to be applied in a different time according to the individual, because we are supposed to be rehabbing individuals not blocks of people that all had an injury on the same day, then it isn't good enough to simply issue edicts. They've got to be based on some consideration of all those factors. That didn't happen and I think it took us a quantum step backwards. And I think some branches have applied good sense and worked around that, others haven't for a range of reasons*.

Most people agreed that some KPIs are perhaps a necessary tool in directing behaviour but comments highlight a number of potential ways forward if vocational rehabilitation is to be provided in ways that meet the goals and intent of the Act including: a) a shift in the focus of KPIs b) good leadership within the corporation and branches c) reconsideration of case managers' skill set and education requirements and d) an emphasis on outcome (not exit). Each of these has a potential role to play in assisting a move towards sensible use and evaluation of processes.

Case manager roles

Some ACC branch staff reported that they felt very positive about their role and about ACC's performance in delivering vocational rehabilitation. However, this was not the

dominant view. Many people (both within and outside ACC) perceived that despite attracting extraordinarily skilled staff to case management positions, many feel hampered in their ability to do what they actually came into ACC to do (such as problem solve, promote rehabilitation). For instance – these two extracts from senior managers indicate the case manager role may benefit from being reconsidered and reconfigured.

> *Most people that come in to the organisation in these sorts of roles want to do the best for their claimant. They're not here to get people off the scheme or whatever … that's not what they're here for. They are here to actually try and return people to independence*

> *As a Case Manager I have never felt so disempowered in all my life and its, some people would say gosh, there's some Case Managers, and I know about it because I've been a provider previously, and I worked with claimants and I used to hear all sorts of stories going on, and now from the other side of that - people used to say gosh there's some Case Managers out there that wield their power. Well there is no power to wield, all you can do is give them the information and provide them with the parameters within which you can work in a nice way or a not nice way, and that's it and do what you can to help them in every way you can but there's no discretion, I mean we don't even make decisions about accepting an application for a request or anything and we process them but basically its based on medical and technical claims input and so we'll have letters written by us, I don't even know that letter went out, and it's a payment.*

A number of stakeholders (and claimants) talked about the workload of case managers as being too great as did claimants. Clearly it was not the remit of this project to evaluate case loads and impact on outcome but there is no doubt that the apparent 'business' is seen to impact on the rehabilitation process as captured in the following extracts:

> *Claimants are saying 'I can't contact them because I know their busy'. I said, how do they know you're busy, there's only one way they know you're busy, because you've told them, so immediately, particularly with older people it sets things up to be difficult…. imagine you ring your case manager on whom you're absolutely dependent for so much stuff and they say I'm busy. Oh god I can't find them they're too busy. The only reason they know is if we tell them, it is not the claimant's issue that we may be under resourced. I say to the case manager don't you ever tell anyone you're busy. Because immediately that sets up a whole power and control thing.*

And

> *I think, yeah, I think from, that again would become a workload issue, people don't feel that they have the capacity to actually take the time out to go back to the person and they also feel that at risk that if they do go back to the person*

that that's going to open them to come back, and it's various reasons why they don't want that to happen I mean

And number of people expressed both concern for the case managers workload but also a frustration stating:

And this is part of the ACC, I mean we've gone back to CMs and we still know they're overworked and underpaid and stressed, but were paying for it, and if you had that type service from someone who is making you a cake or a suit you would complain and ACC don't want to hear that.

A number of people suggested that rather than just increasing the number of case managers, there should be a new emphasis on rehabilitation (rather than claims management). One suggestion that emerged a number of times was to have more administrative assistance to relieve case managers of a function that was essential but did not require their expertise, thereby allowing case managers to attend to their core business (including facilitation of vocational rehabilitation

there needs to be a case manager and maybe per case manager or per two case managers there needs to be an administrator. They can work really closely with that case manager to know what, so they know the caseload, but they do the administrative functions, the case manager does the negotiation, the relationship building.

Clarifying vocational rehabilitation

When many internal ACC stakeholders talked about their role in vocational rehabilitation, it seemed largely related to starting with specific processes such as IRPs, or assessments such as IOA and IMA. However, all good evidence suggests that rehabilitation needs to start early and it is increasingly recognised that that 'early' means at the time of injury or, once medical stability is reached.

All stakeholder groups suggested rehabilitation frequently takes too long to be initiated. Clearly there are a number of claimants where their health state precludes work (for example those who are acutely ill or dangerous to themselves or to others). Further, there are some claimants who despite best attempts, will not achieve a good vocational outcome. However, many people perceived that the risk of a poor outcome is currently exacerbated by delayed rehabilitation.

Whilst there are clearly attempts to predict who requires early referral to a branch for case management, the ability to accurately refer early is clearly dependent on the sufficiency of the data.

There were many discussions about this factor but the following extract captures a number of crucial components:

> *You know preventing the tail rather than actually picking up the pieces is what we need., I think there's real potential for doing that - yeah identifying those people that are going, early risk that are going to end up in the long term claims. .I think they could just stop, probably 90 percent you know there might be the few that still slip through*
>
> *I also think voc rehab needs to go away from just being programmes to actually being what people need, so if they need computers, if they need retraining, if they need how to manage your own business, I just thing it needs to be more personalised, not all about lets do a WPP, let's do a work ready programme.*

However, it is also important to contextualise 'early rehabilitation' with recognition that many claimants reported feeling pushed back to work too early. Active management of this is required given that many claimants may need specific assistance to understand the importance of return to work as soon as possible for their wellbeing or to consider that rehabilitation can indeed occur <u>at</u> work if the appropriate supports are in place.

Expectation setting

In addition, repeated stakeholders echoed the importance but relative lack of early expectation setting with claimants about rehabilitation, their role in that and the importance of work:

> *If we go back to the first contact, I think one of the difficulties with the first contact is it's all about weekly comp. We're not setting some expectations at that point in time about rehab. So rehab is almost something that is secondary to the collection of weekly comp details.*

Most stakeholders agreed there were a number of influences on expectations and that each of these could be improved with two of the key influences identified as being the General Practitioners and ACC case managers.

<u>The General Practitioner:</u> All stakeholders (including the GPs themselves) recognised that they have a crucial role but that there is great variability in GP approach and response:

> *And some of them are fabulous, some of the GPs are great and will really talk to you and some of them will ring up and say well look this person's come back for a medical certificate, I don't really see why they're not working you know what's going on with them, and explain to them what, no they can't they probably can be working but they can't go back to what they were doing so*

> *we're working with them and they say oh do you want a light duties certificate yeah that would be perfect, and you really get a good dialogue going, whereas others 90 days fully unfit, 90 days fully unfit, no I can't discuss this claimant with you over the phone it's a privacy issue.*

However, a number of barriers to GPs promoting appropriate claimant expectations were identified including a) lack of knowledge about the potential long term effects of unnecessary time off (work disability) b) a lack of rehabilitation focus and b) practical constraints such as time availability and current shortage of GPs. The potential tension for GPs was recognised by a number of stakeholders for example:

> *Those employers who've got no company doctor no health practice are really at the whim of the GP, who is the gate keeper. And quite rightly to a yet to be determined point they are the patient advocate. And I have got no problem with that. I think however there was a line which they come up to where they must, or should stop being the patient advocate in terms of the patient advocate and be the rehab advocate.*

And one GP said:

> *I think a lot of the younger ones tend to work towards more rehabilitation, it tends to be some of the older ones and I guess that was their practice, you know when you're seeing so many people a day they want to do that short term fix and hope that the person gets better, not taking in the bigger picture, but I think a lot of the younger ones and certainly with the training now through the college it's improving towards better rehab, but having said that I think some GPs, myself included, we don't know what's available either, and we don't know what questions to as ACC, so you know we get sent out the written papers frequently but sometimes you don't have the time to read them, and so that's why I appreciate that woman coming to talk to us, because you can just ask questions*

This comment points towards the barriers but also captures a repeated theme throughout this study not only with regard to expectations but in general. That is - the importance of face to face communication and teamwork if there are to be shared approaches to rehabilitation and individual claimant management.

ACC: Again all stakeholders identified that both case managers and contact centres have a crucial role in helping claimants form their expectations

> *I used to talk to people right at the beginning when it was apparent that they weren't going to be able to return to work I would say well OK there is some assistance we can give you, but at the end of that assistance there is the VI assessment so it's a finite period so people have that expectation from the beginning*

On the surface, this comment may seem to suggest appropriate expectations are being set early on particularly with regard to the purpose of compensation. However it also

may indicate that the VI process is presented as a 'stick' to control behaviour. Whilst it may be appropriate for some claimants to be managed in this way, it may be that such discussions contribute to the distrustful relationship or power imbalance that both claimants and stakeholders perceived as problematic:

> *And yet you're having to talk about things that you would not normally talk with a stranger about, and people have to be aware of that… the imbalance of power, this relationship with ACC is so imbalanced isn't it? You've got ACC with all the decision making, all the power and all the money, and you've got a claimant who doesn't have a choice. They do not have a choice to be in that relationship. Whereas the case manager can bugger off and go and work at Briscos if they want to because they've got choices. But the claimant doesn't have any choices. So immediately you've got this sort of relationship, so its about how they start getting that relationship into one that actually works. When you've got such an imbalance of power. And control. And some of the case managers, not many, love that. And that's actually why they're here. Because they love to say no, pretending its their chequebook*

Indeed, case managers and providers talked of using a number of techniques in expectation setting such as:

> *What I say to them is, and I use a lot of motivational interviewing, how important is this job to you, what keeps you in that job, what would be the worst thing that would happen, what's holding you back from getting another job, and I try and get them to see the value in getting fit again to get their job and empower them to make the choices to move on. So it's like if you want to get back into the workforce, then use this as a stepping stone to get yourself work fit, because you are going to have much more chance of getting a job with this, this and this.*

Clearly it is important that claimants understand the nature of vocational rehabilitation and the purpose of compensation early on. However, in attempting to help set those expectations, the purpose of the process needs to remain the focus: ie to return people to work and independence, not merely exit.

We briefly note below other aspects of the process stakeholders identified as requiring improvement:

a) identification of those at risk of non-medical work disability at the earliest stage possible (requires good data on risk, good screening and then timely action). Although some comments indicated that such an assessment was done early eg

> *In our region, almost every claimant they get, a worksite assessment is done straight away.*

The case note review and from other stakeholder feedback indicated that improvements (with regard to vocational rehabilitation and assesments) could be made eg:

> *One of the important elements then in any risk assessment is to identify what should be in a branch and get it there quickly. That's really an art form in some ways, there are certain protocols that we are looking for, but one of them isn't this claim needs voc rehab.*
>
> And
>
> *There are still files way down the line that don't even have worksite assessments or accurate reflection of what the person actually did pre-injury…. there might be a whole lot of worksite assessments being done but not actually on the people that are really needing them. So they're not, you know there's sort of like red flags often when you see someone with an injury about whether they're going to return to work or not, and I don't think enough has gone into that, and I think even working with the GP early - Very early on you know things like how much weekly comp they're entitled to is a huge influence on it, the type of injury, whether it's an OOS or a back strain influences whether they're going to be here till that period, whether they're male or female, whether they're from you know lower socio-economic groups, but those sorts of things*

b) targeting and prioritisation of input in ways that reduce the individuals risk of work disability (must match the individual claimant's risk factors and situation).

> *So in terms of early intervention, identifying what the real barriers were, so screening for all the psychosocial issues, identifying when it was a true musculoskeletal problem and even then, is this fitness, endurance, body mechanics, fatigue, age related, whatever, other medical things, and then coming up with a plan of graduated return based on: rehab at work is much better, keeping people in the workplace is much better, dealing with the employer-employee issues in a non-medical way, and just all the normal rehab.*

There was at times reference to intervention provision being limited to 'what the legislation will allow'. However, the legislation is quite flexible in how its fundamental purpose is achieved. It is crucial that fiscal decision making on what is prioritised takes into account long term costs rather than just the short term costs of the most appropriate interventions for claimants.

> *Yes, because there are people in that boat, and there are also people that I think don't get as much as what they could because they're pushed into vocational independence too soon, and I think there's a lot more that could be done in terms of retraining even though I know we're not supposed to retrain, but looking to up-skill people more I mean you look at the spend within ACC on social rehabilitation versus vocational rehabilitation versus weekly compensation, it's just ridiculous, absolutely ridiculous, we spend three times,*

five times as much on social rehabilitation as you know child care home help than what we spend on people doing courses or whatever.

c) establishing relationships and communication built on trust with claimants at the outset (without this, those at risk of long term work disability are likely to disengage)

There is one case manager who is the most upfront person I know and most of her claimants love her, and even people who you know you think God, you can't get away with this, she'll be like, you know great to meet you the first time, I can't wait to help to get you back into the workforce and this is what we're going to do and what do you want to do, and it's all in the, as I said a lot of it in the selling of the process

d) establishing meaningful links with the other team members (including the employer), by good communication to ensure a shared understanding of rehabilitation. A number of stakeholders expressed that indicated there was frequently a lack of shared view and this inevitably contributes to a lack of case coordination. For example a provider stated:

So there was no hands on treatment, it was all liaison, and I remember having a stand up argument with one of the branch medical advisors because he was saying to me, around the fees thing, they had this perception that physio was hands on treatment, and that to charge, you had to be in the cubical with the client, and I said well are you telling me that my liaising with the GP and the case manager and the employer is less important and less of rehab than me standing there massaging this guy. So you'll pay me if I stay in the cubical and talk to the employer, but you won't pay me it I'm out of the cubical. He said that's right, and I said how ridiculous and hung up. So that's their perception

All employers expressed a great deal of keenness to work towards contributing to the rehabilitation process for their employees. However, also expressed frustration regarding their lack of inclusion and with what they saw as an assessment processes that frequently postponed rather than facilitated early return:

The case managers from employer's perspectives are rarely 'thunders' but they aren't involved. Because the case manager will only talk with the employee, its only when they want to come back to work they'll start having the OT's come in and doing the workplace assessments and nauseating reports, I mean just get back to work.

I've seen a person having 15-20 assessments rather than just treat the conditions. Which is kid of dumb in a way, and the patients die before they get it. In other cases, case manager from ACC, I'm not sure why they do this, but

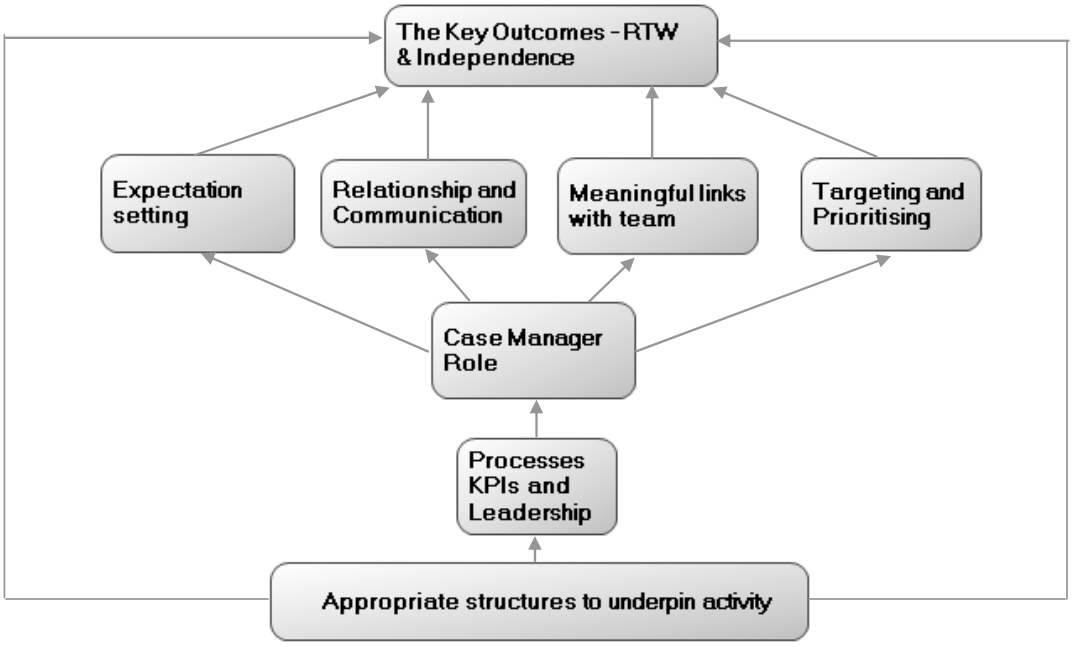
the patient is assessed to death, OT after OT after OT…. that from an employers perspective slows the process down and looking for improvements I think the CM need to - as a second point of contact in the first couple of days - make contact with the employer.

Summary of stakeholder views

We have attempted to capture here the key factors that appear to impact on stakeholder involvement in and satisfaction with current vocational rehabilitation process. It is interesting to note that there is a great deal of similarity between stakeholder views and claimant data – both within the case note review and more qualitative descriptions of experience.

The figure below highlights that the various factors discussed above seem to relate in a complex but clearly interrelated manner. Our suggestion is that a model comprising these factors is not necessarily inappropriate. However, recognition about the relationships between factors and the impact each has on the key goal of improved outcome is essential. Whilst the core 'activities' of assessment, intervention and actions are indeed crucial, the figure below suggests a clear structure (that is explicitly linked to the desired outcome) is required to drive all processes.

Figure 9 Proposed relationship between factors identified by stakeholders



Key conclusions and recommendations are represented in the following section.

Key findings, conclusions and recommendations

An enormous amount of data has been collected from multiple sources in exploring the extent to which the goals and intent of the legislation are being met with regard to vocational rehabilitation. Significantly - there was remarkable consensus amongst claimants, ACC stakeholders and other stakeholders about the key issues confronting claimants and the corporation in developing a more responsive approach. This bodes well for moving forward and continuing to improve the structures, processes and outcomes of vocational rehabilitation.

Clearly the complexity of vocational rehabilitation means that there will be errors, omissions and occasions where management falls below the standard we would aim to deliver thereby failing to achieve the best outcomes for claimants. However - what an organisation does when it discovers these things is what really that matters. As one (internal to ACC) stakeholder said:

> *Its one thing to fail a claimant in a particular event or something, it's another thing to let it go on and on and on, and for some reason there are some cases where this has happened or appears to have happened. How that can possibly come about - it just leaves me gobsmacked, I don't understand it at all, and I think that's very sad and a sad reflection.*

This report aims to clearly highlight key areas of performance where improvement is required. However, we have attempted to report in such a way that ACC, as a learning organisation, can move forward in its drive to deliver vocational rehabilitation that reflects the goals and intent of the legislation.

In addition to the specific summary below, Appendix 10 includes consideration of how ACC might apply the 10 key rules for quality improvement that were developed by the Committee on the Quality of Health Care in America in 2001[14]. This has been reproduced from a report some members of the team provided to ACC in 2006[15].

[14] Committee on Quality of Health Care in America, Crossing the quality chasm: a new health system for the 21st century. 2001, Washington D.C.: National Academy Press.
[15] Kayes, N. McPherson, K.M. Reid D. Complex Assessment Project. A Report commissioned by the Accident Compensation Corporation March 2006

Questions that were posed at the beginning of the research are now revisited with a summary of key findings associated with each question.

1) *What are the specific indicators (criteria of success) for meeting the intent and goals of the Act across all processes and outcomes in Vocational Rehabilitation?*
   A set of criteria were developed in consultation with ACC and others (Appendix 1). These were globally summarised in 15 key domains with clear definitions specifying whether the legislative intent was met. This tool is provided in Appendix 2.

2) *To what extent is current practice in assessment, rehabilitation processes and outcomes achieved, addressing the specific criteria identified.*
   There are significant indications that improvement in assessment and rehabilitation processes are required with around 70% of claimant records requiring improvement in each domain in order to meet the goals and intent of the Act. The results section points to a number of specific findings regarding which claimants are particularly at risk of receiving vocational rehabilitation that is not in keeping with the goals and intent of the Act in particular:
   - Evidence that ethnicity was considered for claimants was lacking in the case records. Specifically, Maori were significantly less likely to be assessed as having vocational rehabilitation that met the standard defined for meeting the goals and intent of the Act.[16]
   - Those with back/spinal injury appeared least likely to have the standard met.
   - Perhaps surprisingly, vocational rehabilitation for participants who sustained their injury at work was significantly less likely to meet the standard.
   - Claimants where there were multiple case managers (those with 3 or more in the first year) were least most likely to have the standard met
   - The degree to which the goals and intent of the Act are met (as measured in the Global Domains) related to work status at the time of survey.
   - Provider assessments and interventions are of variable quality and appropriateness (indicated by data from claimant survey, case note review, expert review of IOA and IMA process, claimant and stakeholder interviews).

[16] Caution is required in interpreting ethnicity data as the numbers of non-European/others was so low.

3) *What are the strengths and weaknesses in current approaches that are being used in relation to addressing the intent and goal of the Act?*

Appendix 8 provides a proposed pathway to facilitate an expansion of best practice. Appendix 9 provides two 'best' practice examples from within the claimant group.

Weaknesses in current approaches were also identified with each aspect of the review showing improvement to be required. Claimant and stakeholder perspectives as well as the survey and case note data highlighted a number of structures and processes that contribute to the current situation in particular:

- The role of case managers appears currently focused predominately on compensation and claim management with rehabilitation frequently being secondary or indeed, not apparent.
- The nature and effect of Key Performance Indicators (particularly those which drive behaviour that is not focused on rehabilitation and/or compromises claimant centred rehabilitation for RTW and independence).
- The connection between the assessment processes, claimant needs and consequent actions is frequently limited.
- Key tools for rehabilitation (such as IRPs) rarely include claimant goals.
- A lack of early intervention. This requires improved risk assessment and prioritisation if costs are to be managed appropriately.
- A lack of team work. This appears partly associated with workload issues (also requires improved prioritisation) but also due to an apparent lack of shared perspective on rehabilitation (see below).
- A fundamental barrier to working with a number of claimants, (and achieving good outcomes for those with complex conditions and circumstances), is that relationship building may be overlooked in its key role for case managers.
- Current vocational rehabilitation focuses on standard packages of intervention, many of which are lacking evidence of effectiveness, rather than being tailored to the individual claimant requirements

4) *How do the various stakeholders perceive their role and that of others in supporting Vocational Rehabilitation processes and outcomes as embodied in the Act?*

   All stakeholders agreed that they had key roles in supporting vocational rehabilitation. However – significant problems were highlighted and include:

   - A lack of 'meaningful' communication between stakeholders
   - Difficulty in allocating resources/time needed for appropriate involvement in vocational rehabilitation
   - Lack of early involvement of the appropriate parties (including the GP, employer and other stakeholders).

   A Vocational Pathway and recommended stakeholder role is provided in Appendix 8.

5) *What are the components of 'best practice' in Vocational Rehabilitation with specific reference to meeting the intent and goals of the Act?*

   Best practice components have been highlighted in two case presentations (Appendix 9) and include:

   - Early and accurate assessment of entitlement.
   - Early expectation setting to include a clear focus on rehabilitation.
   - Development of a two way relationship of trust with claimants and other stakeholders in the process (demands good communication, transparency and clear identification of each person's role).
   - Early identification of those at risk of protracted work disability with management strategies focused on those risk factors.
   - Accurate assessment of the consequences of injury beyond biomedical considerations to include social and psychological factors. All claimants who are needing to be off work due to injury are at risk of these factors impacting on their engagement in vocational rehabilitation and return to work outcome
   - Targeted interventions that relate to individual claimant assessments.
   - Outcome driven (RTW and independence) as opposed to output driven (exit) vocational rehabilitation.
   - High quality professionalism, appropriate knowledge and competency in core skills in both ACC stakeholders and providers.

6) What are the ramifications of these findings in relation to current practice and future development of policy and practice in vocational rehabilitation?

Answering this question also provides the key recommendations that emerge from the research.

Key Recommendations

There are three fundamental areas where we would suggest findings point to reconsideration of practice and policy in Vocational Rehabilitation. These are also presented in the Executive Summary.

Key recommendations

1. Improved evidence about outcome is required:

1.1 to underpin and improve risk assessment and prioritisation of services

1.2 to determine the efficacy of specific vocational rehabilitation interventions to ensure appropriate allocation of funding and resources

1.3 evaluating the cost effectiveness of what appear high 'up front' cost rehabilitation strategies such as education and retraining in contributing to better long term outcomes (improved return to work and independence and therefore reduced long term costs for ACC and other government services)

2. Revised structures (staffing, documentation for case management, documentation for audit and review) are required:

2.1 presenting a higher profile on 'rehabilitation'[17] in ACC's image and promotional material. It is noteworthy that whilst the word, and it's meaning, feature greatly in the legislation, it is absent from much of the promotional material of ACC, including the logo.

[17] It has been shown that *recovery* is taken to mean *back to the same state as prior to injury* by many people. However *rehabilitation* includes a focus on living with altered abilities and ongoing consequences of a condition. This semantic difference is potentially very significant.

2.2 to provide and support a model of case management focused on rehabilitation as well as claim management, particularly important for those at risk of long term work disability.

2.3 by restructuring documentation such as IRPs to facilitate whole of person assessment and involvement of the individual in goal setting.

2.4 to underpin contracting with providers of both assessment and interventions to allow whole of person consideration - of paramount importance for those at high risk of inappropriate work disability.

2.5 to facilitate standardisation of high quality service that is never-the-less individualised.

2.6 that facilitate and support processes focused on rehabilitation early in a claimant's association with ACC (see below).

3. A review of core processes is proposed:

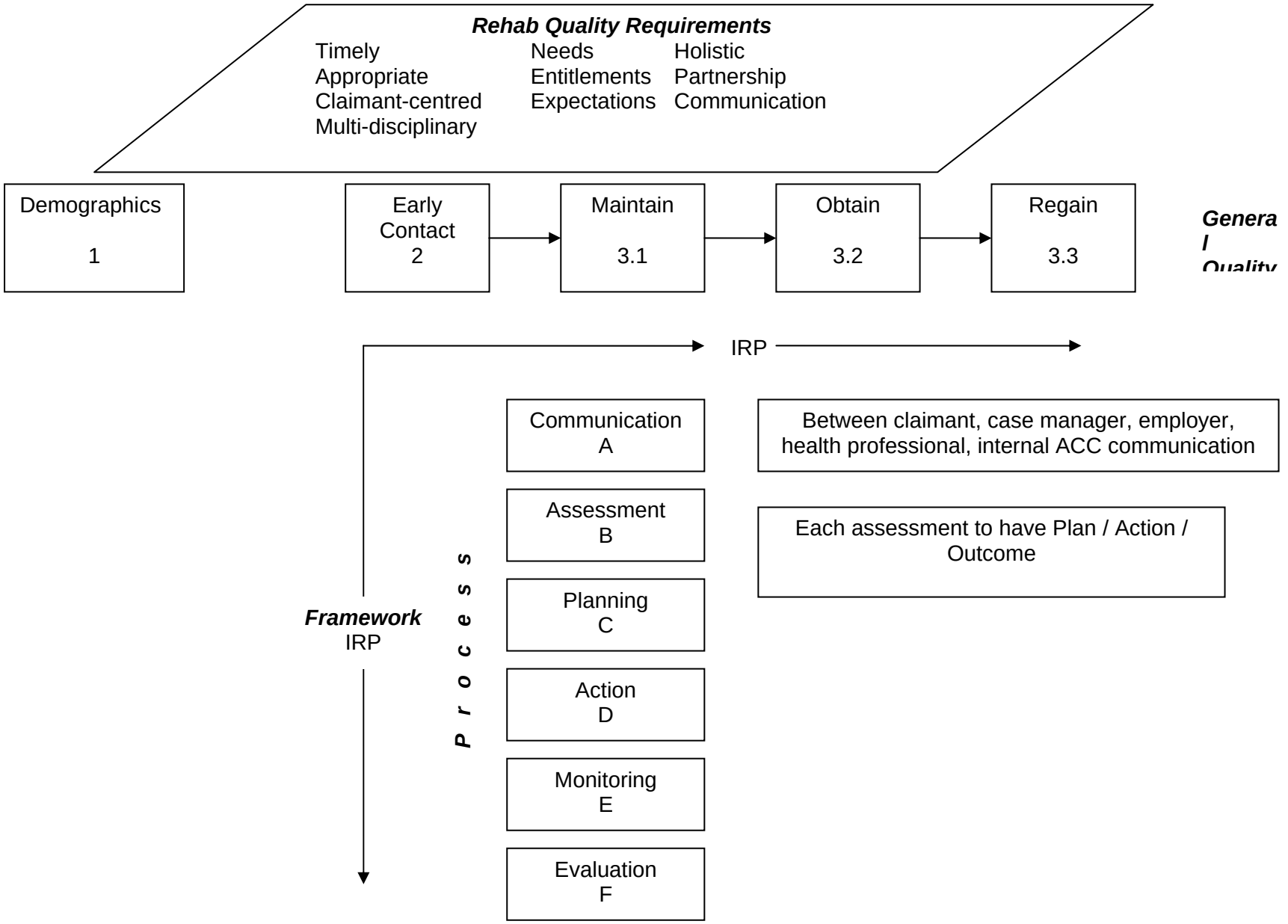
3.1 to ensure they relate to the overall purpose and intent of the Act and are focused on improving outcome rather than being an end in themselves

3.2 to maximise claimant involvement and engagement in the process of return to work and vocational rehabilitation. An urgent review of approaches to expectation setting, communication and power sharing are required.

3.3 to facilitate the engagement of all stakeholders in the most appropriate manner depending on each claimant and their circumstances. Whilst a number of claimants may not return to their pre-injury work and some may not return to work at all, early and appropriate involvement of all stakeholders has potential to minimise this risk.

Appendices

Appendix 1: Specific criteria model and checklist



AUT Number	
Administrator	

CT	Looking For	Notes of Evidence	Comments	Database
1.	Ethnicity			
2.	Family circumstances	Dependent children (under 18yrs) ☐ Yes ☐ No ☐ Don't know Dependent others (caring for others) ☐ Yes ☐ No ☐ Don't know ☐ Lives alone ☐ Lives with independent family/friends ☐ Don't Know		
3.	Number of prior claims	No of prior claims _____		
4.	Delayed incapacity initial injury? Delayed incapacity due to surgery? Gradual process investigated?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No		
5.	Work-related injury	☐ Yes ☐ No		
6.	Employment situation	Self employed ☐ Yes ☐ No ☐ Both		
7.	Duration of incapacity Estimated recovery time	Standard: min to max Expected: (days) Delay		
8.	Number of Case Managers Communication of changes in case mgmt from ACC	No of CM _____ (year 1) No of CM _____ (year 2) ☐ Yes ☐ No ☐ N/A From whom? ☐ New CM ☐ Old CM		

		☐ Other If yes ☐ Face to face ☐ Letter ☐ Phone call		
9.	Support person/Advocate	Support Person involved? ☐ Yes ☐ No What stage? ☐ EC ☐ M ☐ O ☐ R		
10.	Conflict Noted	Conflict? ☐ Yes ☐ No With whom? ☐ CC ☐ CM ☐ BM ☐ HP ☐ E Other _____ Where in process? ☐ T ☐ Ax ☐ Com ☐ SerP ☐ Ent ☐ IRP ☐ Other _____ How conflict resolved? ☐ M ☐ CsC ☐ TL ☐ BM ☐ Ad ☐ CLRev ☐ CLA ☐ Never resolved Other _____		CC = case co-ordinator, CM= case mgr, BM= branch provider, HP= health provider, E=employer T= treatment, Ax = assessment, Com= communication, SerP= service provision, Ent= entitlement M=mediation, CsC= case conference, TL= team leader input, BM = branch mgr input, Ad= advocacy services, CLRev = claimant initiates review, CLA = claimant imitates legal action
11.	Date of initial interview	Date __/__/__		
12.	Consent obtained and Code of Rights discussed/given	Verbal (initial inter) ☐ Yes ☐ No Form rcvd signd ☐ Yes ☐ No ☐ N/A Code of Rights sent ☐ Yes ☐ No		
13.	Communicating expectations of participating in voc rehab	☐ Yes ☐ No ☐ Letter ☐ Phone ☐ Meeting		Mode L = letter, P= phone, M= meeting

14.	Communication about any other pre-existing medical conditions /disabilities barriers for RTW	Any identified? ☐ Yes ☐ No Injuries _____ Medical conditions _____		
15.	At work straight after injury?	☐ Yes ☐ No		
16.	Any change to work situation since injury?	☐ Yes ☐ No ☐ Don't Know If yes what? ☐ RH ☐ L/S ☐ UNF ☐ NoLD ☐ Other _____		RH = reduced hours, L/S = light/selected duties, UNF = unfit for work, NoLD= no light duties
17.	Initial medical incapacity	Medical cert. Date __ / __ / __ Initial # days off ____ ☐ light duties ☐ fully unfit		
18.	Any initial vocational rehabilitation offered?	☐ Yes ☐ No		
19.	Plan developed from the initial recommendations of the assessments and information collected? Early Direction of overall Voc Rehab	☐ Yes ☐ In part ☐ No Verbal plan Date __/__/__ Formalised plan Date __/__/__ ☐ SESR ☐ SEDR ☐ SRDE ☐ DRDE ☐ Unidentified		SESR= same empl same role, SEDR= same empl diff role, SRDE= same role diff emp, DRDE= diff role diff empl.

Maintain – Obtained - Regain merged

CT	Looking For:	Notes of Evidence	Comments	Database
20.	On-going ACC and employer communication re: progress	☐ Yes ☐ In part ☐ No ☐ S/E Mode? ☐ Phone ☐ Letter ☐ Meeting Other _____		Rank mode of communication (1= most freq, 3= least freq)

		With whom? ☐ Employer ☐ Self-employed ☐ Line manager/Supervisor ☐ Other _____		
21.	Evidence of claimant disclosing self circumstances	☐ Yes ☐ In Part ☐ No ☐ Cant tell With whom? ☐ ACC ☐ SP ☐ TP ☐ As ☐ E Other _____		ACC = case co-ordinator or case mgr, SP= service provider, TP= treatment provider, E=employer
22.	Identification of other problem factors that could impact on voc rehab identified?	☐ Yes ☐ No ☐ ADL ☐ Pain ☐ Mobility ☐ Cognition ☐ Emotional ☐ Behavioural ☐ Drug and alcohol ☐ Economic ☐ Occupational ☐ Social / family ☐ Other _____		
23.	Evidence of assessment	Assessment Physio __/__/__ GP __/__/__ OT __/__/__ Occupational Physician __/__/__ Psychologist __/__/__ Counselling __/__/__ A & D services __/__/__ Neuro-psych __/__/__ Specialist- medical __/__/__ Specialist- pain __/__/__ Financial advisors __/__/__ Career advisors __/__/__ Carer/support __/__/__ Other _____ __/__/__		

24.	Evidence of treatment	Date of 1st treatment Physio __/__/__ GP __/__/__ OT __/__/__ Surgery __/__/__ Occupational Physician __/__/__ Psychologist __/__/__ Counselling __/__/__ A & D services __/__/__ Neuro-psych __/__/__ Specialist–medical __/__/__ Specialist - pain __/__/__ Financial advisors __/__/__ Career advisors __/__/__ Carer/support __/__/__ Other _____ __/__/__		
25.	Functional job description obtained for ACC and by whom	☐ Yes ☐ No ☐ N/A Functional JD Date __/__/__ ☐ Claimant ☐ Employer ☐ Assessor ☐ other _____		
26.	Worksite	Worksite Assessment? ☐ Yes ☐ No By whom _____ Visited? ☐ Yes ☐ No By whom _____		
27.	Claimant receiving information about treatment	☐ Yes ☐ In part ☐ No Forms of communication ☐ From ACC ☐ From health provider ☐ From voc provider		
28.	Communication to claimant about purpose of assessment	☐ Yes ☐ In Part ☐ No ☐ No assessment By whom? ☐ ACC representative ☐ Assessor		

29.	Discussion of ongoing social needs / usual life roles impacted by injury identified	Claimant/family initiated ☐ A ☐ U ☐ O ☐ N ACC initiated ☐ A ☐ U ☐ O ☐ N Provider initiated ☐ A ☐ U ☐ O ☐ N **Parental impact** (eg. Childcare) ☐ 1-off ☐ On-going ☐ No Provided? ☐ Yes ☐ No ☐ N/A __/__/__ What provided? _____ **Other caring roles** ☐ 1-off ☐ On-going ☐ No Provided? ☐ Yes ☐ No ☐ N/A __/__/__ What provided? _____ **Home impact** (eg. Home help, aids, modifications) ☐ 1-off ☐ On-going ☐ No Provided? ☐ Yes ☐ No ☐ N/A __/__/__ What provided? _____ **Accessibility impact** (eg. Transportation) ☐ 1-off ☐ On-going ☐ No Provided? ☐ Yes ☐ No ☐ N/A __/__/__ What provided? _____ **Leisure impact** (eg. Interests) ☐ 1-off ☐ On-going ☐ No Provided? ☐ Yes ☐ No ☐ N/A __/__/__		A= always, U= usually, O= occasionally, N= never Minor aids (eg for ADL's) Major aids (major modifications eg house)

		What provided? _____ **Other** _____ ☐ 1-off ☐ On-going ☐ No Provided? ☐ Yes ☐ No ☐ N/A __/__/__ What provided? _____		
30.	Entitlements	Discussed ☐ Yes ☐ No ☐ In part Assessed ☐ Yes ☐ No ☐ In part		
31.	Claimant receives copies of reports & assessments	☐ Yes ☐ No ☐ In part ☐ No assessments		
32.	Have assessments recommendations been actioned?	☐ A ☐ U ☐ O ☐ N ☐ No assessments		A= always, U= usually, O= occasionally, N= never
33.	Evidence of claimant & CM negotiating goals?	Negotiating? ☐ Yes ☐ No ☐ In part Mode of dialogue ☐ L ☐ P ☐ M ☐ CC		Mode L = letter, P= phone, M= meeting, CC= case conference
34.	Evidence of appropriate parties included in implementation of plan	☐ Yes ☐ No ☐ In part ☐ Claimant ☐ Employer ☐ Supervisor ☐ Colleagues ☐ Family ☐ Support person/Advocate ☐ G.P ☐ Other treatment provider ☐ Service provider ☐ Other _____		
35.	Plans/IRP	Plan/IRP developed?		

	developed from the recommendations of the assessments and information collected?	☐ Yes ☐ No Plan/IRP informed by assessments? ☐ Yes ☐ No ☐ In part ☐ No Ax **Medical (IMA)** ☐ Yes ☐ No ☐ In part ☐ No Ax **Occupational (IOA)** ☐ Yes ☐ No ☐ In part ☐ No Ax		
36.	Claimant input into overall plan/IRP Evidence of claimant & ACC disagree over plan/IRP?	☐ Yes ☐ No ☐ In part ☐ No Plan/IRP ☐ Yes ☐ No		
37.	Plan/IRP reflects overall claimant's situation (needs and injury)	IRP reflects the direction of overall Voc Rehab process and the claimants situation ☐ Yes ☐ No ☐ In part ☐ No Plan/IRP Treatment ☐ Yes ☐ No ☐ In part Physical ☐ Yes ☐ No ☐ In part Social ☐ Yes ☐ No ☐ In part Employment ☐ Yes ☐ No ☐ In part Occupation ☐ Yes ☐ No ☐ In part Psychological ☐ Yes ☐ No ☐ In part Other _____ ☐ Yes ☐ No ☐ In part		
38.	Plan/IRP objectives achieved?	☐ Yes ☐ No ☐ In part ☐ No Plan/IRP		
39.	Communication between those involved in returning to work	With whom? ACC with Cl/ HP/ Empl/ SP ☐ Yes ☐ No ☐ In part Claimant with ACC/ HP/ Empl/ SP ☐ Yes ☐ No ☐ In part HP with Claim/ACC/Empl/ SP ☐ Yes ☐ No ☐ In part		HP = health professional, SP = service provider, Cl = claimant, Empl = employer

		SP with Claim/ACC/Empl/HP ☐ Yes ☐ No ☐ In part How? ☐ Group/meeting ☐ 1:1 (meeting or phone) ☐ Correspondence		
40.	Evidence of following up claimant returning to work	☐ Yes ☐ In part ☐ No By whom? ☐ ACC ☐ Other		
41.	Barriers to work identified during RTW Transition period Action taken to address barriers?	☐ Yes ☐ In part ☐ No Date __/__/__ ☐ No modified duties ☐ Workplace unsuitable ☐ Lack of safety equipment ☐ Pain / concentration / tiredness ☐ Physical injury limitations ☐ Transportation ☐ Other _____ **obtain/regain** ☐ Other skills needed ☐ No accessibility to appropriate jobs ☐ No suitable workplaces ☐ Other _____ ☐ Yes ☐ In part ☐ No Date __/__/__ ☐ No modified duties ☐ Workplace unsuitable ☐ Lack of safety equipment ☐ Pain / concentration / tiredness ☐ Physical injury limitations ☐ Transportation ☐ Other _____ ☐ Yes ☐ In part ☐ No Date __/__/__ ☐ Intervention ☐ Service referred ☐ Assessment		

42.	Plan/IRP updated as relevant	Plan/IRP1 Date __/__/__ Plan/IRP2 Date __/__/__ A / B / C / D / E / F/ G / H Plan/IRP3 Date __/__/__ A / B / C / D / E / F/ G / H Plan/IRP4 Date __/__/__ A / B / C / D / E / F/ G / H		A. updated assessments B. meeting objectives / goals C. change in focus – obtain regain D. not meeting goals E. unsuccessful return to work F. VIMA declares **not** yet work capable G. Regular monitoring process H. Claimant feedback
43.	Case outcome	Claim still open? ☐ Yes ☐ No If yes at June 06 are they ☐ Not evident ☐ Back at work ☐ Not at work ☐ Receiving weekly comp At case closure or at 1 year after injury do they have a job? ☐ Yes ☐ No ☐ Not evident Participating in activities paid or unpaid directed at RTW? ☐ Yes ☐ In Part ☐ No ☐ Not evident Injury re-occurrence? ☐ Yes ☐ No ☐ Had further surgery		

Maintain only

44.	Case Manager communication with (employer) line manager about maintaining current employment	☐ Yes ☐ In part ☐ S/E ☐ No Extenuating circumstances ☐ Date __/__/__ Position _____ Content of communication ☐ Pay details ☐ Leave ☐ Job still available? ☐ Yes ☐ No ☐ How long ☐ Changing physical environment ☐ Light duties ☐ Flexible hours ☐ Workplace assessment co-ordination		

Obtain and Regain only

45.	Plan/IRP objectives reflect the overall rehab goal Plans developed to obtain work and services aimed at achieving goal?	☐ A ☐ U ☐ O ☐ N ☐ No Plan/IRP ☐ Yes ☐ In part ☐ No ☐ Voc counselling and guidance (ie career counselling ☐ Work Preparation (eg CV, interviewing) ☐ Training (eg training courses) ☐ Job seeking ☐ Work re-adjustment (eg work hardening) ☐ Work trial (eg job appropriate) ☐ Medical and treatment (eg pain management and PT) ☐ Other _____		A= always, U= usually, O= occasionally, N= never Voc guidance = IOA, voc sessions Work prep = WPP Training = computer skills (WPP), other training courses Job seeking = voc sessions, trans job search (TJS), WPP Work re-adjust = ABP, WPP, GRTW Work hardening = ABP, OT supervised work trial, GRTWWork trial = actual job, OT supervised trial, GRTW, work ready (WRP) Medical & treatment = PT, ABP, pain management program

Appendix 2: Global indicators reflecting key goals and intent

Guide to global ratings of the claimant's Vocational Rehabilitation Journey[18]
To score 1 = must be better than the definition of 2 - To score 4 = does not meet the definition of 3
When in doubt – score down (as appropriate in quality)

	Domain	Definition of 'meets expectation' = 2	Definition of 'some improvement required' = 3
1	Claimant centeredness	The claimant and their situation has been considered within their life context at all stages of the Vocational Rehabilitation process (whether or not a formal vocational rehabilitation plan or IRP has been instituted in the case of those on claim <13 weeks).	Limited account of the claimant's perspective or their life context throughout their Vocational Rehabilitation Process.
2	Expectation setting	The claimant has been made appropriately aware of their role and potential to contribute to the process of vocational rehabilitation and to achieve the most positive outcome possible.	Some evidence that the claimant has been made appropriately aware of their role
3	Claimant accountability	The claimant has made all reasonable appropriate steps towards involving themselves in steps required for their vocational rehabilitation	The claimant has some steps towards being involved in their VR
4	ACC communication with the claimant	Clear communication between ACC and the claimant about all aspects of their vocational rehabilitation	Lacking evidence of full communication with claimant
5	Team makeup	All relevant members are involved across claimant/family and employer/health/voc rehab/ACC that should promote a positive process (assessment, planning and interventions) as well as successful outcome	Some relevant members of the team not involved
6	Information gathering	All efforts to gather information that will assist a positive process and successful outcome have been made	Some failure in key information gathering steps
7	Whole team communication	Appropriate strategies put into place to enable communication within and between the different team members in the vocational rehabilitation journey (claimant/family/employer/health/voc rehab/ACC)	Some gaps in team communication
8	Relationship building and maintenance	Appropriate steps towards establishing and maintaining a relationship with the claimant that promotes positive vocational rehabilitation processes and successful outcomes throughout the claimants journey	Only partial evidence that steps to establish or maintain relationships taken (ie one way or limited)
9	Implementation	A clear and transparent pathway	Little transparent pathway underpinning

[18] The term Vocational Rehabilitation Journey is used to ensure that the changing nature of the claimant's situation, experience is encapsulated throughout the whole episode of claim.

	of plan / decision making	underpinning all decisions taken on assessment, intervention and cessation of claim (if relevant)	decisions
10	Evaluation and monitoring	Proactive and full evaluation of claimant progress throughout the vocational rehabilitation journey	Some limit to completeness and/or proactive nature of evaluation and/or monitoring
11	Overall timeliness	The timing of all contacts, communication, assessments, interventions, information giving, etc has been appropriate throughout the vocational rehabilitation journey	Some lack of matching on the timing of all contacts or assessments or interventions or information giving or communication, etc
12	Overall appropriateness	The most appropriate approach to the claimant's vocational rehabilitation has been in place throughout the vocational rehabilitation journey taking all things into account including the claimant, their condition and their context	Taking all things into account, some limits to appropriateness in the approach to the claimants VR and/or some limits in considering the claimants context and condition
13	ACC facilitation of maintaining work role	All reasonable appropriate efforts to maintain the claimant in their work role have been made before considering the next stage of 'obtaining' a different role	Efforts fall short of what might be anticipated
14	ACC facilitation of obtaining work role	If maintenance has not been possible, all efforts to OBTAIN a different role or other employment with the same role have been made	Efforts fall short of what might be anticipated
15	ACC facilitation of regaining work capacity	In the case that the claimant has had to move into REGAINING a new work capacity, all appropriate efforts have been made to facilitate this stage of the vocational rehabilitation process.	Efforts fall short of what might be anticipated

Appendix 3a: Mapping criteria to global rating scales

	Global Rating Domain	**Criteria ID number of the criteria to which relates to**
1	Claimant centeredness	1, 2, 3, 6, 14, 22, 25, 26, 29, 33, 34, 35, 37, 41, 45
2	Expectation setting	7, 13, 21, 33
3	Claimant accountability	12, 13, 21, 36
4	ACC communication with claimant	8, 10, 13, 21, 28, 29, 31, 33, 39
5	Team makeup	9, 20, 23, 24, 34, 44
6	Information gathering	1, 2, 3, 11, 14, 15, 16, 17, 20, 22, 23, 25, 27, 29, 33, 35, 37, 41, 44, 45
7	Whole team communication	9, 20, 21, 27, 28, 31, 34, 39, 44
8	Relationship building and maintenance	8, 9, 10, 12, 21, 27, 29, 33, 37, 39, 40
9	Implementation of plan / decision making	19, 29, 30, 32, 34, 35, 36, 37, 38, 40, 41, 42, 45
10	Evaluation and monitoring	19, 20, 22, 25, 26, 29, 32, 37, 38, 39, 40, 41, 42, 45
11	Overall timeliness	4, 11, 14, 18, 19, 20, 23, 24, 25, 29, 32, 41, 42, 44
12	Overall appropriateness	1, 2, 3, 4, 10, 14, 21, 22, 23, 24, 25, 26, 29, 30, 31, 32, 33, 34, 35, 36, 37, 39, 41, 42, 44, 45
13	ACC facilitation of maintaining work role	3, 6, 11, 15, 16, 19, 20, 22, 23, 24, 25, 26, 29, 30, 32, 33, 34, 35, 36, 37, 39, 40, 41, 42, 44
14	ACC facilitation of obtaining work role	19, 20, 22, 25, 26, 29, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 45
15	ACC facilitation of regaining work role	19, 20, 22, 25, 26, 29, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 45

Appendix 3b Data regarding specific criteria in case note review

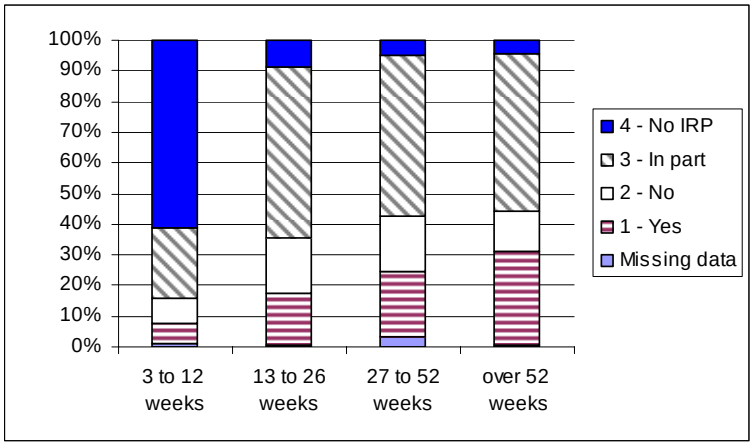
We highlight below a selection of criteria item data. Further analysis of specific criteria is available on request.

Planning

Claimant input into the IRP

106 (19%) of claimants were reviewed as having had input to their IRP. 255 (47%) contributed only in part (ie in a very limited capacity such as agreeing to the listed actions). Eighty claimants (15%) had no input into their Individual Rehabilitation Plans (IRP). A further 98 (18%) did not have any plans (predominately in the early strata as one might expect). The figure below summarise the level of input of claimant into plans in each strata.

Figure 10 Claimant input into plans (Criteria Q36)

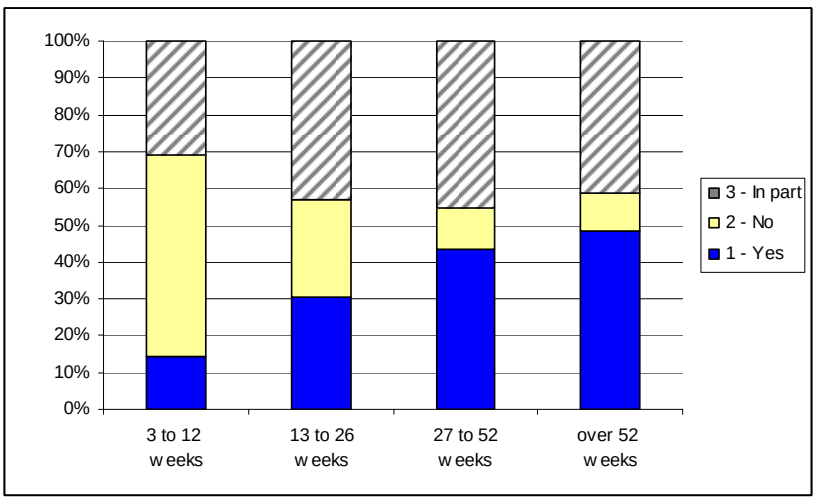


Of those claimants who were on weekly compensation from 3 to 12 weeks, 61% (73) had no plans compared to 4% (6) over 52 weeks.

Negotiating goals

Overall, only a third (34%, 185) of cases had evidence that goals were clearly negotiated between claimants and case managers and 22% (123) had no negotiation.

Figure 11 Evidence of claimant and case manager negotiating goals (Q33)



Plan reflecting claimant's situation

Claimant's receiving weekly compensation for longer than 52 weeks 37% (53) were more likely to have plans that reflected a whole of person approach. The two main areas that the plans did not include were the social (63%, 345) and psychological (55%, 301) consequences of injury and context of rehabilitation.

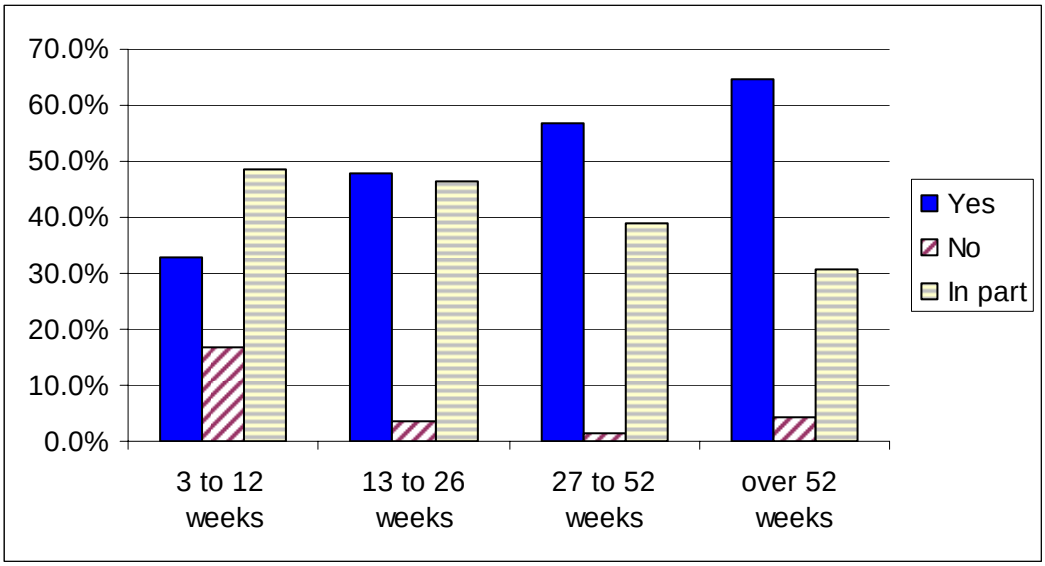
Table 21 Relationship between the plan and claimant's overall situation (Q37)

Relationship between IRP and claimant overall situation	3 to 12 weeks	13 to 26 weeks	27 to 52 weeks	over 52 weeks	Total
Yes	12 (9%)	32 (22%)	45 (32%)	53 (37%)	142
No	4 (11%)	14 (39%)	11 (31%)	7 (19%)	36
In part	30 (11%)	80 (30%)	78 (30%)	76 (29%)	264
No plan	71 (74%)	12 (13%)	8 (8%)	5 (5%)	96
No data	2 (22%)	0 (0)	4 (45%)	3 (33%)	9
Total	119 (22%)	138 (25%)	146 (27%)	144 (26%)	547

ACC communication with claimants, health professionals, employers and service providers

ACC communication about returning to work was more frequent for claimants on compensation in the fourth strata (or over 54 weeks). High rates of 'in part' communication reflect a reliance on postal and one way communication rather than face to face or team meetings.

Figure 12 ACC communication with stakeholders (Q39)



Communication between other stakeholders

Only 39% (46) of claimants appeared to be engaged in communication with each stakeholder involved in their vocational rehabilitation.

Appendix 3c Work versus not work related injury

Initial feedback from ACC regarding the report raised some questions about why people who were injured at work appeared to receive lower quality vocational rehabilitation than those injured elsewhere. There was particular interest in exploring whether the provider of claim management services may have contributed to that finding. As a result, the research team undertook an additional analysis presented in the table below.

Table 22 Frequencies and crude analysis relating predictor variables separately to participants injured at their workplace dichotomised ratings of their vocational rehabilitation journey using GEE analysis after adjusting for the design stratification variable. Note that we model the event of interest being ACC as meeting the standard.

	Baseline		GEE results		
	n	(%)	Estimate	(95% CI)	P
Sex					0.52
Female	48	(22)	0	Reference	
Male	172	(78)	-0.09	(-0.34, 0.17)	
Age					0.07
<40	42	(19)	0	Reference	
40-49	62	(28)	0.33	(-0.01, 0.67)	
50-59	52	(24)	0.17	(-0.19, 0.53)	
≥ 60	64	(29)	0.38	(-0.01, 0.69)	
Ethnicity *9 (4.1%) participants had observations missing*					0.10
Maori	18	(9)	-0.27	(-0.56, 0.03)	
Pacific	1	(0)	0.60	(0.39, 0.81)	
Asian	0	(0)	-	-	
European/other	192	(91)	0	Reference	
Residential location					0.32
Urban	80	(36)	0	Reference	
Rural	140	(64)	-0.11	(-0.33, 0.10)	
Injury site category					0.05
Back/Spine	73	(33)	0	Reference	
Lower limb	54	(25)	0.08	(-0.18, 0.34)	
Upper limb	79	(36)	0.14	(-0.15, 0.42)	
Head	9	(4)	0.71	(-0.09, 1.50)	
Abdomen/Pelvis/Chest	5	(2)	0.36	(-0.23, 0.95)	
Number of prior claims *15 (6.8%) participants had observations missing.*					0.20
0-4	55	(27)	0	Reference	
5-7	43	(21)	-0.08	(-0.42, 0.27)	
8-12	54	(26)	-0.16	(-0.45, 0.13)	
≥13	53	(26)	-0.26	(-0.57, 0.05)	
Third party provider					0.97
No	198	(90)	0	Reference	
Yes	22	(10)	0.01	(-0.35, -0.36)	
Number case managers within the first year *5 (2.3%) participants observations missing.*					0.12
0	6	(3)	-0.23	(-0.54, 0.08)	
1	83	(39)	0	Reference	
2	68	(32)	-0.11	(-0.38, 0.17)	
≥ 3	58	(27)	-0.16	(-0.42, 0.11)	

Key findings are that the main contributing factors to quality in this subgroup (ie of those injured at work) is very similar to that for the overall population

- The third party provider cases appear to have very similar levels of quality of service as to those managed by ACC
- Overall, the only factor that is statistically significant in relation to the difference in quality is injury site. Injury site is therefore the main influence and people with backpain experience the lowest quality of service.
- Ethnicity is overall not a significant contributor. However, in keeping with our finding for the total population, Maori fare worse (indicated by the negative value when compared with the reference group – in this case Pakeha – NZ European).

Appendix 4: Inter rater reliability on global rating scales

% added and divided by the number of raters (3)
Mean and range

Initial blinded assessment 4 files (1-4)

Domain	Rater Agreement				
1	57% (0-100%)	6	33% (0-100%)	11	89% (67-100%)
2	43% (0-100%)	7	11% (33%)	12	56% (67-100%)
3	78% (33-100%)	8	56% (67-100%)	13	44% (33-100%)
4	100% (100%)	9	43% (33-100%)	14	78% (33-100%)
5	78% (33-100%)	10	33% (100%)	15	100% (100%)

Total Assessment 2 & 3 (25 files)

Domain	Rater Agreement				
1	59% (38-100)	6	66% (54-75)	11	60% (38-80)
2	59% (38-100)	7	93% (88-100)	12	66% (60-75)
3	77% (63-100)	8	72% (62-80)	13	63% (40-88)
4	55% (46-70)	9	63% (54-75)	14	90% (88-92)
5	78% (70-88)	10	67% (46-80)	15	96% (88-100)

Adjusted Total Assessment 2 & 3 (25 files) subsequent to training and following key process instructions of a) if in doubt discuss with other rather b) if any doubt - rate lowest rating in keeping with usual quality evaluation

Domain	Rater Agreement				
1	83% (69-100)	6	78% (69-90)	11	88% (85-90)
2	86% (77-100)	7	93% (88-100)	12	86% (69-100)
3	88% (77-100)	8	85% (77-90)	13	86% (77-100)
4	73% (63-80)	9	85% (77-90)	14	96% (88-100)
5	88% (85-90)	10	83% (69-100)	15	96% (88-100)

Appendix 5: Recruitment strategy

Criteria	Detail	Timeframe
Contact 1: "prenotice" letter	From ACC	Week 1
Contact 2: mailing the actual survey instrument that includes a detailed cover letter, which explains why their response is important	From ACC or its representative	Week 2/3
Contact 3: thank-you postcard sent to the participants approximately a week after the survey is mailed, which expresses appreciation for their response, or if it has not yet been mailed, urges the recipient to respond either to ACC's representative or the research team 0800 number.	From ACC or its representative	Week 4/5
Contact four: contact constitutes a replacement survey, in case the original got lost or destroyed	From ACC or its representative	Week 6/7
Contact five: contact is a telephone reiterating the importance and the value of their response and engaging in phone interview or obtaining permission for the researchers to phone the claimant.	From ACC or its representative	Week 8

Final sample size = 1000 was aimed for. Anticipating a 65% response rate, 1600 claimants were included in the potential pool.

Strata	**N aim to contact**
3 to 12 weeks of weekly compensation	400
13 to 26 weeks	400
27 to 52 weeks	400
Over 52 weeks	400
Total	1600

Proposed Process for Facilitating Participation in the study

Step 1: ACC and our statistician (Professor Philip Schluter) will liaise over extracting the data for the 1600 claimants

Step 2: Contact details for claimants only (ie no other personal information from the data-dump) will be provided to ACC's subcontracted agency facilitating recruitment.

Step 3: Contact 1- Prenotice letter will be sent to all claimants by ACC's subcontracted agency facilitating recruitment.

Step 4: AUT researchers will update ACC's subcontracted agency weekly concerning responders who contact AUT directly either to return questionnaires, to take part in telephone interview or to ask not to be contacted again.

Step 5: Contact 2 – letter and questionnaire pack will be sent to all claimants by ACC's subcontracted agency with a stamped addressed envelope to researchers will be posted to all claimants.

Step 6: AUT researchers will update ACC's subcontracted agency weekly concerning responders who contact AUT directly either to return questionnaires, to take part in telephone interview or to ask not to be contacted again.

Step 7: Contact 3 - Thankyou postcard and reminder will be posted to all claimants except for those who request no further contact.

Step 8: AUT researchers will update ACC's subcontracted agency weekly concerning responders who contact AUT directly either to return questionnaires, to take part in telephone interview or to ask not to be contacted again.

Step 9: Contact 4 – A replacement survey will be sent to all those who have not responded and have not requested no further contact.

Step 8: AUT researchers will update ACC's subcontracted agency weekly concerning responders who contact AUT directly either to return questionnaires, to take part in telephone interview or to ask not to be contacted again.

Step 10: Contact 5 –claimants who have as yet not responded will be telephoned by ACC's subcontracted agency. The importance and value of their participation in the research will be reiterated and permission sought for the researchers to phone the claimant to take part in a telephone interview. Repeated attempts to obtain claimants should be made – suggest three per claimant.

Appendix 6: Claimant Experience of Vocational Rehabilitation Questionnaire

Your experience of managing/attempting return to work after injury.

- Phone our 0508 VOC REH (0800 862 734) if you would like help with this questionnaire.
- Please think of the time around your injury and claim with ACC during 2003/2004.

1.	What part of your body did you injure that led you to need ACC compensation during 2003/4?	
2.	What was the date of your injury?	--/--/--
3.	a) What was the title of your job prior to this claim? _____ b) What sorts of things did you do in the job? (eg driving, answering the phone, administration, data entry, teaching etc) Write down as many activities as you like. c) How many hours per week did you work prior to this claim? _____	

- **Please tick <u>ONE</u> box for each question as <u>best fits</u> your experience.**

4.	Which statement <u>best describes</u> your situation: I returned to the same work position as prior to my claim..... I returned to a different work position with the same employer..... I returned to the same work position but different employer..... I returned to a different work position and different employer..... I did not go back to work after my injury.....		☐ ☐ ☐ ☐ ☐
5.	Are you working now?	Yes..... No.....	☐ ☐
6.	How many hours do you work compared to before your claim?	More ..... The same ..... Less ..... I'm not working.....	☐ ☐ ☐ ☐
7.	Was your claim due to an injury at work?	Yes..... No.....	☐ ☐
8.	If you changed your work *<u>or</u>* did not go back to work, was this because of your injury?	Yes..... No..... Not Applicable.....	☐ ☐ ☐
9.	How long after your injury was it until someone talked with you about things that might help you get back to work?	Within 2 weeks..... Within 6 weeks..... Within 3 months..... Over 3 months..... Never.....	☐ ☐ ☐ ☐ ☐
10.	Please tell us what <u>you expected of ACC</u> in helping you get back to work?		
11.	Please tell us what you think <u>ACC expected of you</u> in trying to get back to work?		

12.	Who did you get information from about things that might help you get back to work?		
13.	Did you have any difficulties trying to return to work?	Yes No Not applicable	☐ ☐ ☐
14.	Did you have any difficulties coping at work when you returned?	Yes No Not applicable	☐ ☐ ☐
If Yes, please describe:			
15.	Would you say your return to work was successful?	Yes No In part	☐ ☐ ☐
If No or in part - please describe:			
16.	Do you think you tried to go back to work too soon?	Yes No	☐ ☐
17.	After your injury and claim, how long did your first attempt at work last?	Less than 3 months 3 to 5 months 6 to 9 months Longer than 9 months I did not go back	☐ ☐ ☐ ☐ ☐
18.	How much time off did you have due to your injury in the first 6 months after returning to work?	More than 4 weeks 1 to 4 weeks Less than a week None I am not working	☐ ☐ ☐ ☐ ☐
19.	Has the injury that took you off work continued to cause you difficulty?	Yes No	☐ ☐
If Yes – please tell us more about this			
20.	Have you experienced another injury since your claim that has made it hard to work?	Yes No	☐ ☐
If Yes – please tell us more about this			
21.	What level of responsibility do you have at work compared with before your injury?	More The same Less I'm not working	☐ ☐ ☐ ☐
22.	What level of satisfaction do you get from your work compared with before your injury?	More The same Less I'm not working	☐ ☐ ☐ ☐
23.	What level of salary/income per week do you receive compared with before your injury (including benefits/compensation)?	More The same Less	☐ ☐ ☐

24.	Have you been promoted in your job since returning after injury?	Yes No I'm not working	☐ ☐ ☐
25.	What level of co-worker support did you have for getting back to work?	Excellent Good Not much None Not applicable	☐ ☐ ☐ ☐ ☐
26.	What level of employer or supervisor support/assistance/accommodations did you have for getting back to work?	Excellent Good Not much None Not applicable	☐ ☐ ☐ ☐ ☐
If your employer/supervisor gave support - please tell us more about what that was:			
27.	What level of help did you get from health professionals for getting back to work?	Excellent Good Not much None	☐ ☐ ☐ ☐
Please tell us what sort of health professional provided that help and what they did:			
28.	What level of ACC contact centre/case manager support/assistance did you have for getting back to work?	Excellent Good Not much None	☐ ☐ ☐ ☐
If ACC gave support - please tell us who provided that help and what they did:			
29.	What level of support from family/friends did you have for getting back to work?	Excellent Good Not much None	☐ ☐ ☐ ☐
30.	Were your own ideas and goals for returning to work taken into account by ACC?	Yes No	☐ ☐
31.	How involved did you feel in setting goals for your return to work (even if you have not returned to work)?	Very involved A little Not at all	☐ ☐ ☐
32.	Were your family / whanau involved in the process of looking at returning to work in the way you wanted?	Yes No	☐ ☐
33.	Were managing the other roles in your life that are important to you (such as being a parent) considered in how ACC managed your case?	Yes In part No	☐ ☐ ☐
34.	Were managing other activities that are important to you (such as doing things in your home, hobbies) considered in how ACC managed your case?	Yes In part No	☐ ☐ ☐
35.	All things considered – was your return to work timely? (eg did you feel ready, prepared)	Yes In part No I did not go back at all	☐ ☐ ☐ ☐
Please describe:			

36.	Did you get the help you needed at the right time (even if you did not go back to work)?	Yes…… In part…… No ……	☐ ☐ ☐

Please describe:

37.	All things considered – did the help ACC organised regarding your work seem <u>appropriate</u> for you? (eg did it help in the ways you needed help?)	Yes…… In part…… No ……	☐ ☐ ☐

If No or In part - please describe:

If there were any particular <u>things that made it hard</u> or <u>things that helped</u> you in getting back to work please tell us about that in the box below.

39) Any things that made getting back to work <u>harder</u>?

40) Any things that <u>really helped</u>?

41) Any things that, thinking back<u>, could have helped more</u>?

Thank you for taking the time to answer these questions.

Appendix 7: Data security measures

Process of keeping ACC files confidential

Receiving files from ACC

- Contact details for courier includes a mobile number (NM)
- Where possible someone in office on a regular basis
- Spoken directly to courier about where to deliver if no one in office
- Notice on door to indicate where next secure delivery point is (secure reception area)

Storage of data

- This key accesses a locked filing cabinet, only those directly involved with the data and part of the research team know where the keys are stored for the filing cabinets that contain the data.
- Data has been filed using our unique identifier number.
- Consent forms and questionnaire/criteria data has been stored in separate filing cabinets to ensure that identification of claimants remains anonymous.
- Electronic storage of the data has been kept within a folder that only the research team has access to.

Transportation of data

- Researchers will use identified bags/boxes to transport files to and from AUT and ACC (Sales St and North harbour).
- These bags will be kept on the researchers person at all times and not left in vehicles or public places.
- Case files will be stored overnight at the branches if researchers are heading home from the branch rather than taking them home.
- In emergency if files are to be stored at home, they are to be stored in a locked cabinet.

Transmission of data

- E-mailed claimant information is saved into the hard-drive or on disks then deleted from the in-box, trash and sent items.
- Files for specialist review will be transported by a member of the team.

Process for collecting data (criteria) from ACC branches

- Take files from storage and sign out on sheet what numbers and who is taking them to ACC.
- See above for transportation of data to ACC.

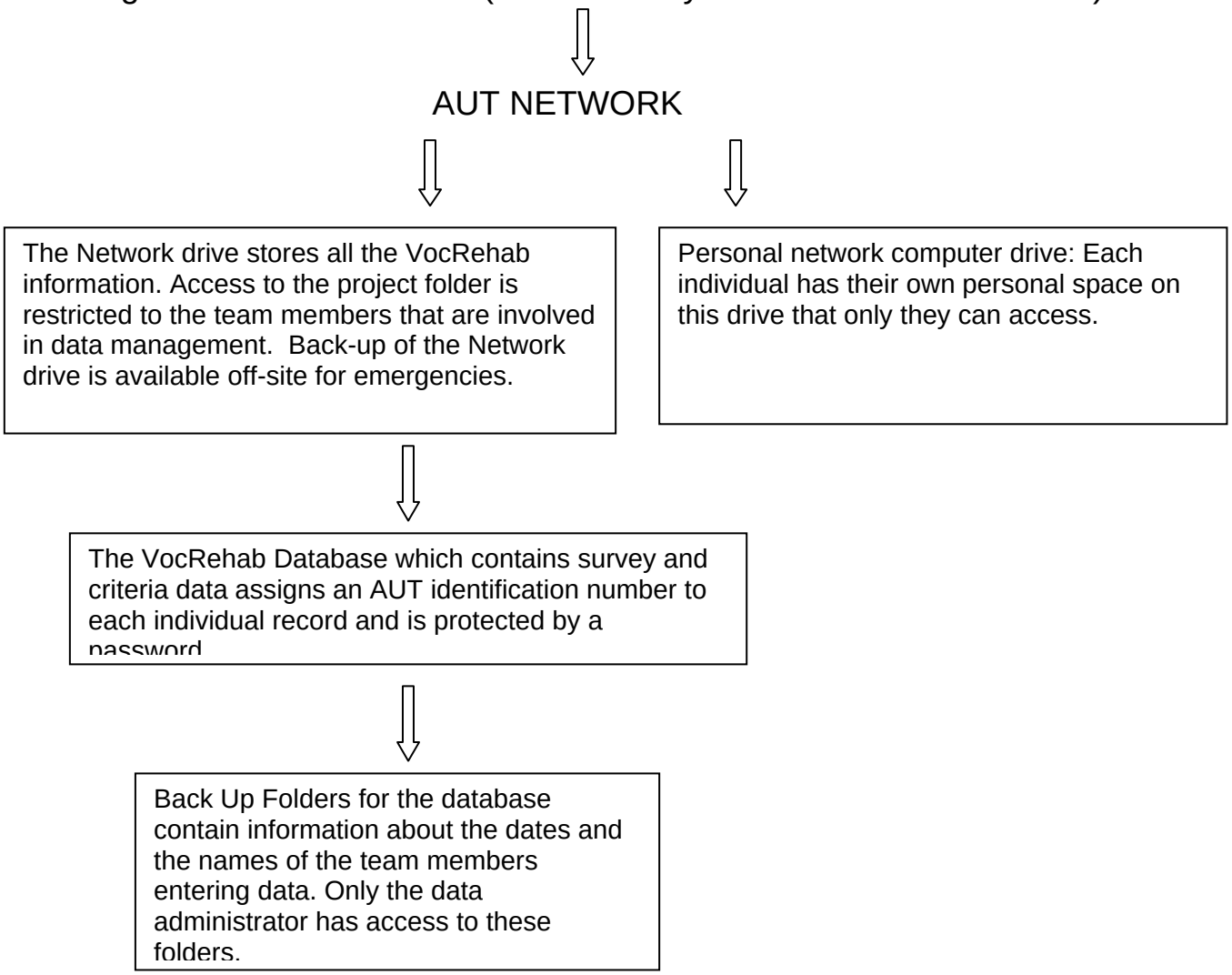
- As collecting information, take note of any problems or the numbers of cases which you are having difficulty with for discussion with the rest of the team.
- Read first through the file to get familiar with it (pathway and case note).
- Tick the front and write done on the front of the file when completed collecting pathway & case note information.
- When finished for the day, take the filled out criteria templates to home/office and if need be leave the case files at ACC overnight**.**
- On way to work pick up files (or continue collecting) and when back at AUT sign files back in and file in correct drawer.
- Update external data storage of files that have had (case note) CN assessed and (pathway) PW assessed.
- File criteria templates in filing cabinet 2 (2nd drawer) by our unique identifier.
- Write on list in office the unique identifier number of case files who you think need to be followed up with medical/occupational assessment or interview.

Destruction of data (sending to ACC for destruction)

- Remove our unique identifier from case file
- Update external data storage as when sending file out
- Place files in blue bins provided by Online Document Destruction Services. Contact company for bins to be picked up and documents to be shredded.
- Delete from the floppy disks provided by ACC all claimant information.

Project Data Storage

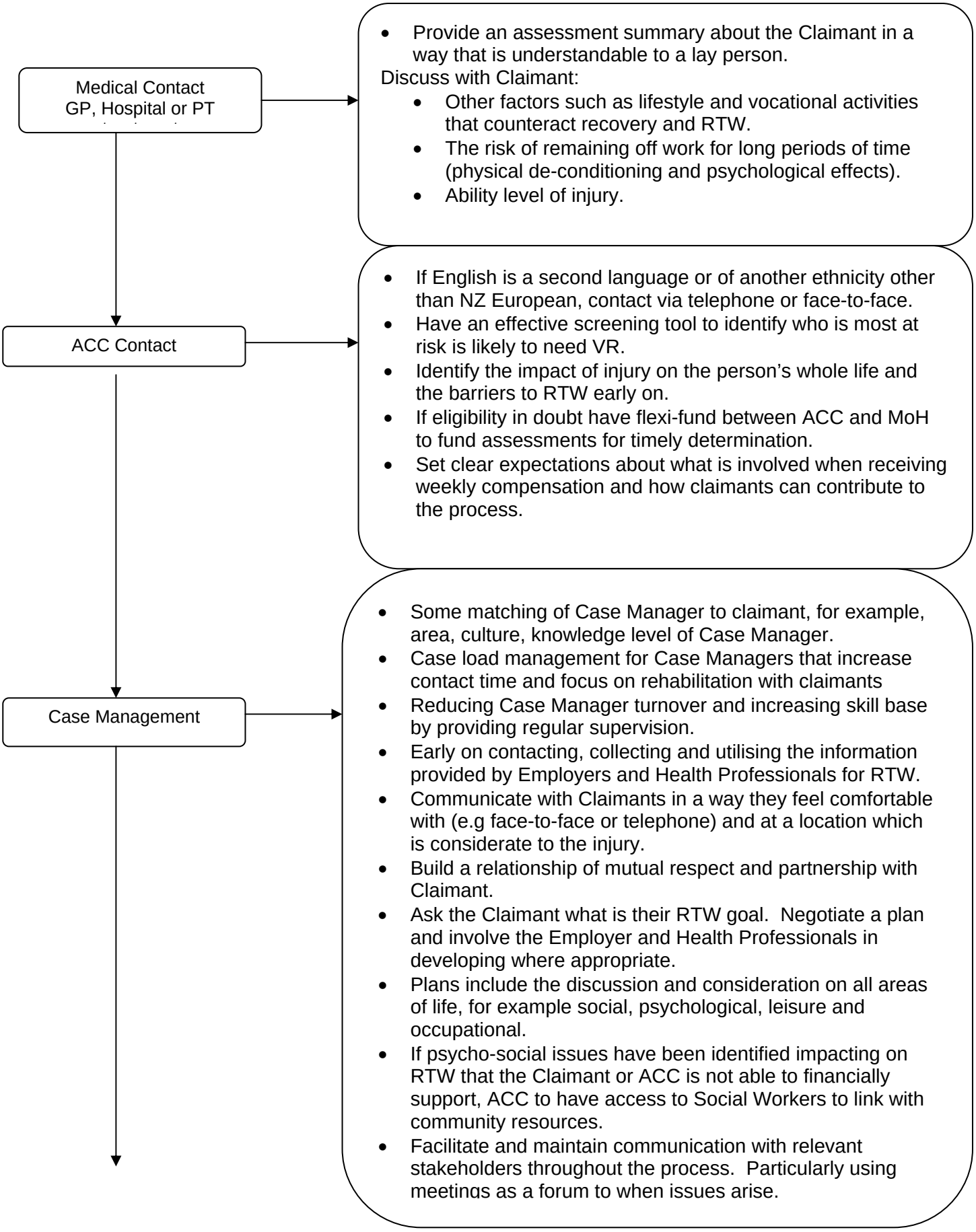
Log in to AUT NETWORK (available only to AUT staff and students)

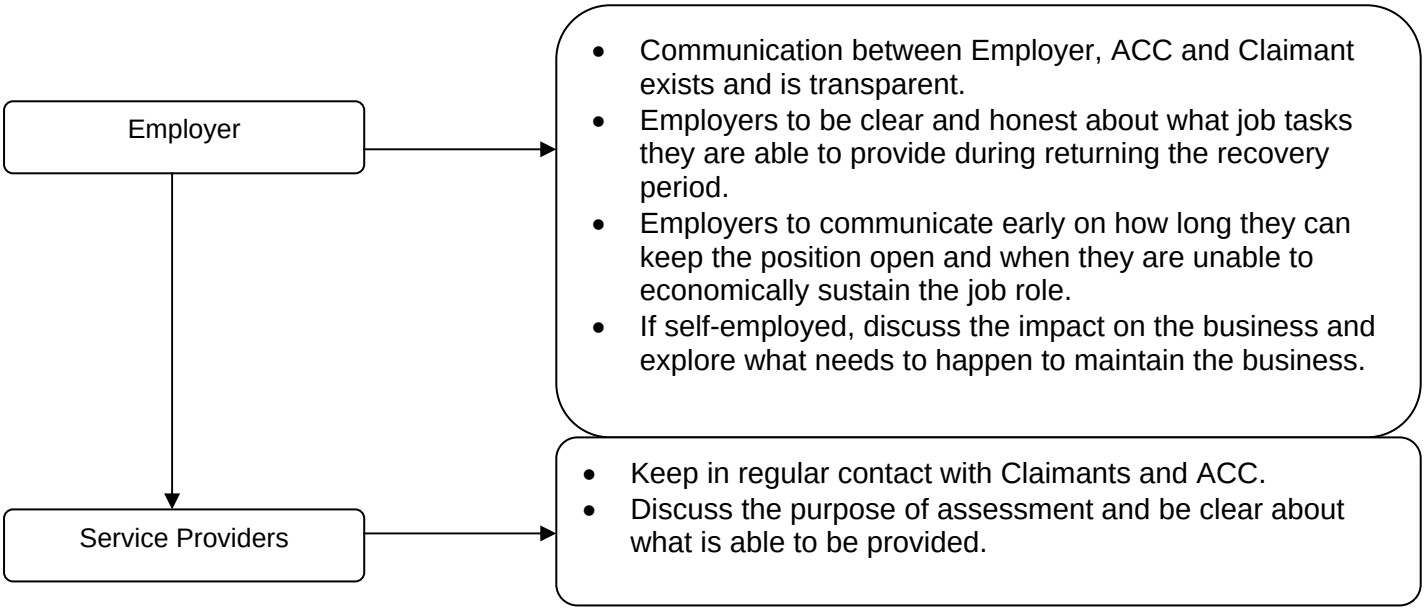


Additionally we have information on:

1. External data storage – contains AUT participant IDs, claimants' names and addresses. This is the electronic version of the consent form data. This external data storage has a password which is restricted to those involved in data input and is locked away. Paper copies of the consent forms are also locked away. Only those involved in data entry have access to this storage.
2. CD ROM 1– contains BRC IDs and contact details. The CD contains a password which only two team members know (the project and data managers). This CD is locked in a filing cabinet.
3. CD ROM 2 – contains AUT ID and the corresponding ACC ID. This data is protected with password and locked up in a different location to the other data. Only two members of the team know the password (principal investigator and the data manager).
4. ACC Case Notes and Questionnaire data (hard copies) – locked up in filing cabinets with restricted access, only those directly involved with the data have access. This room is protected with a combination lock.
5. Floppy disks – demographic information provided by ACC. The claimants are only identifiable by an ACC identification number. This is stored in a locked filing cabinet with access only to the research team.

Appendix 8: Vocational Rehabilitation Pathway




Employer
Service Providers
Communication between Employer, ACC and Claimant exists and is transparent.
Employers to be clear and honest about what job tasks they are able to provide during returning the recovery period.
Employers to communicate early on how long they can keep the position open and when they are unable to economically sustain the job role.
If self-employed, discuss the impact on the business and explore what needs to happen to maintain the business.
Keep in regular contact with Claimants and ACC.
Discuss the purpose of assessment and be clear about what is able to be provided.

Appendix 9: Best Practice Case Examples

Case 1
In 2004 Mr Y experienced a shoulder injury and was a 60 year old male at the time of his injury who. He worked as a full-time, self-employed builder before his injury and he was able to return to the same job. Mr Y lived and was supported by the services in the Otago region.

Relationship building, maintenance and communication with claimant
Mr Y and the case manager built a relationship in which empathy and encouraging attitude assisted this process. The case manager and Mr Y kept in regular contact with each other throughout the rehabilitation process, particularly following up Mr Y as he was returning to work and discussing goals.

From face to face interview with claimant
Mr Y: I found the communication between the case manager and myself excellent. I had such a good working relationship with the case manager and the GP and I think probably the understanding of the case manager is very important.

Interviewer: Tell me a bit more about the understanding. Was that in terms of their knowledge or the way they related?

Mr Y: Yeah and probably their public relations and being able to handle personnel. That if you get somebody who's arrogant and bumptious and negative, I would think that would be a real problem, but when you get somebody who's quiet and helpful rather than negative, it makes a big difference, even if the end result is a negative, being a positive thinking person is a terrific help.

Overall timeliness
The timing of contacts, assessments, interventions and information gathering was considered appropriate for Mr Y's situation. ACC contacted Mr Y shortly after he had notified ACC of his injury and when a case manager was allocated Mr Y was contacted to negotiate a plan. Mr Y's Individual Rehabilitation Plans were updated on a regular basis and included consideration of a range of factors important to Mr Y and his return to work plans.

An Initial Occupation and Medical Assessment were completed after surgery and a period of recovery and when it appeared that Mr Y would not be able to return to his prior occupation.

These assessments lead on to specific interventions that resulted in Mr Y obtaining another job. Whilst he obtained that job himself, and understood that was his role, he perceived the assistance from ACC and from providers as helping him achieve that outcome.

Case 2 (305)

Mr X is a 44 year old male who suffered a head injury and facial wounds in 2004. Prior to his injury he worked 50-60 hours per week in a retail situation. Mr X has a wife and two daughters. His case is currently managed in Auckland. His claim still open as he was unable to maintain his prior job and full-time employment. Mr X is currently looking for employment. The factors that facilitated the vocational rehabilitation process are discussed below.

From face to face interview with claimant

Interviewer: What do you think are the two or three most important things that ACC do provide?

Mr X: Well the fact that ACC offered all those different people to check me out to see how I am. To check my eyes, my ears, concentration levels and speech therapy, that's very good. Then the occupation therapist seeing me on a regular basis and then the case manager ringing me up every now and again, just to catch up and see how I am.

Team makeup and communication

Throughout the vocational process Mr X's wife, work colleagues, General Practitioner, Physiotherapist, Speech and Language Therapist and case manager were actively involved. Regular meetings and reports with family, health professionals and the claimant were evident throughout the rehabilitation process.

Mr X's case manager was involved in a multi-disciplinary meeting within the first month of the injury which identified the assessments needed to facilitate returning to work and independence. The meeting minutes were documented.

When referring to service providers and health professionals the case manager included brief background information about Mr X which facilitated inter-team communication. Communication about return to work and ongoing vocational rehabilitation was evident between Mr X's GP and the case manager.

Information gathering, evaluation and monitoring

As a result of effective team communication appropriate and timely assessments were identified for example, a driving assessment, neuro-psychological assessments, speech-language evaluations. Recommendations and interventions from the assessments were implemented, particularly when stress was identified when gradually returning to work. Regular progress reports from the various health professionals were sent to the case manager and were followed up.

Relationship building, maintenance and communication with claimant

This began with a letter to Mr X which communicated a clear expectation of the relationship in appropriate language. It was noted that this letter differed from the standard letters sent to claimants

Excerpt from letter sent to claimant from case manager

As your case manager, I will work in partnership with you to set objectives and goals, co-ordinate the services you require, liaise with medical practitioner and advocates (if applicable). This is to provide you with an effective rehabilitation programme and ensure a safe and timely return to some or all of your pre-accident activities.

Regular contact, by both telephone and meetings between Mr X and his case manager has continued throughout the rehabilitation process. Mr X has had one case manager over the past 2 years. This has facilitated maintaining a relationship with ACC. Communication about when and why an assessment is taking place has been discussed and correspondence sent to Mr X. This has facilitated clear communication and is appropriate for Mr X and his cognitive abilities.

Appendix 10: Quality and ACC

This appendix presents the recommendations from the earlier report as readers may find it helpful.

Kayes, N. McPherson, K.M. Reid D. Complex Assessment Project. A Report commissioned by the Accident Compensation Corporation March 2006

Working in Partnership

ACC should work in partnership with claimants at all stages throughout the rehabilitation process. Working in partnership can include:

- Maintaining a transparent relationship with the claimant
- Involving claimants in case conferences and ensuring the case conference is enabling the claimant to benefit from the proceedings by considering the balance of power between the claimant, health providers and ACC representatives; respecting the claimants opinions and views; ensuring the claimant has an opportunity to speak; and allowing the claimant to attend with a family member or other advocate.
- Ensuring the case manager is accessible to the claimant.
- Working towards common goals.

Adopting a Claimant-centred Approach

Adopting a claimant-centred approach is critical to establishing a positive case manager-claimant relationship. In addition to this, it is an important step in developing claimant-centred goals. Some important steps in adopting a claimant-centred approach could include:

- Getting to know the claimant and what is meaningful and important to that claimant: including their hobbies and interests, their family circumstances, their living situation - and develop the rehabilitation plan using a 'whole-person' approach.
- Identify the claimant's needs, goals and desires and establish goals relating to these.
- Respect the claimant's opinion and views and take them seriously.
- Be an advocate for the claimant – negotiate on behalf of the claimant.
- Provide an individualised service that takes into consideration the claimants needs and understanding, and acknowledge new developments in the claimant's physical and social environments.
- It is clearly important that this means more than a shift in rhetoric. Evidence suggests outcomes are likely to be enhanced and sustained by adopting such an approach.

Multi-disciplinary Working

Multidisciplinary working is critical to the development of an evidence-based structured rehabilitation plan and should include continuous communication between ACC, health professionals and the claimant at all times throughout the rehabilitation process. Some recommendations include:

- Case conferences would provide a good forum for multi-disciplinary communication, particularly when developing the rehabilitation plan. This gives health providers an opportunity to consider the claimant as a whole and prioritise their recommendations to formulate an evidence based rehabilitation plan. This also reduces the responsibility of the case manager to interpret sometimes complex medical information on their own. Case conferences also provide an opportunity to communicate and discuss the recommendations with the claimant.
- Case managers should utilise the experts available to them, both internally and externally.
- Communication with health providers and rehabilitation services should continue outside of case conferences.

Improving Communication

An important part of maintaining a positive case manager-claimant relationship is ensuring that the communication with the claimant is open. However, the method of communication is also important when delivering a message to a claimant and could be a catalyst to action or inaction by the claimant. Some suggestions of how communication could be improved include:

- When communicating a message to a claimant a case manager should consider how they (the 'source' of the message), the message itself and the claimant (the 'audience') might impact on how that message is received. For example, they should ensure they are a credible source who is knowledgeable and confident. They should also consider the claimants educational level, their personal circumstances and cultural understanding and how this might impact on how they communicate a message. Lastly, they need to consider what the message is they are trying to get across.
- Case managers should openly communicate with the claimant at all times throughout the rehabilitation process – with regards to what they are doing and what the claimant can expect. This should also include open communication when a file is being transferred between case managers.

Developing Case Manager Education and Training

A formalised, targeted, and indeed compulsory education and training package delivered to ACC staff would be beneficial (including but not limited to case managers). The areas that could be covered in this training package include:

- Communication skills training.
- Orientation to rehabilitation services and providers where case managers most likely to make referrals.
- Specialist training in relation to specific diagnostic groups (e.g. traumatic brain injury, chronic pain).
- Familiarisation of important rehabilitation processes, such as goal setting and specialist training on putting this into practice.
- Identifying and managing the risk factors for poor prognosis.

Supportive Organisational Structures

ACC's organisational structures should support case managers and enable them to deliver a claimant-centred, multi-disciplinary, evidence-based service and rehabilitation plan to claimants. Some ways that the organisational structure could be adapted to be more supportive include:

- Provide a supportive environment for staff (e.g. active management of caseload, supportive team leaders) and value staff.
- Adapt health provider contracts to include funding for time spent on multi-disciplinary working.
- Ensure health providers have a responsibility to provide a service for the claimant as well as fulfil a contract to ACC (e.g. make it the health provider's responsibility to ensure the claimant understands their diagnosis and is equipped with strategies to manage their symptoms).
- Review the structure of the review panel system.
- Set up the documentation systems to allow for changes to be made so that documentation is up to date and reflects the individual's current circumstances.
- Develop policies and procedures that promote transparency, claimant-centred working and working in partnership (e.g. exit strategies for transfer of files, cultural responsiveness, consent and disclosure, etc).
- Ensure the key performance indicators enable the case manager to provide a claimant-centred, individualised rehabilitation plan.

A Quality Model to Consider?

The Committee on the Quality of Health Care in America began developing a strategy in 1998 that aimed to improve the quality of health care in America. In 2001 they released *Crossing the Quality Chasm: A New Health System for the 21st Century* concluding that in order to improve the quality of healthcare, the health system needs to be redesigned. They suggest ten rules that we should follow when developing and

redesigning the health system. Whilst ACC is not a health care service, it is uncanny how closely the ten rules they have suggested relate to the key recommendations we have made above. We recommend that ACC consider the model the Committee on the Quality of Health Care in America have developed and the ten rules they have suggested and how they might apply to ACC.

The ten rules are outlined below, along with suggestions as to how they might relate to the themes and recommendations outlined in this report:

1. Care based on continuous healing relationships

This rule purports that a patient should 'receive care whenever they need it and in many forms'. We have highlighted throughout this report the importance of the case manager-claimant relationship and of maintaining open communication with the claimant and being accessible.

2. Customisation based on patient needs and values

By this, the committee suggest that whilst a service can be designed to meet the most common type of need, it should also have the flexibility to be responsive to individual needs. This links closely with our recommendation that ACC should ensure that they are adopting a claimant-centred approach. This will impact on the trust a claimant has in ACC and the likelihood that they will adhere to their rehabilitation plan.

3. The patient as the source of control

This again links closely with adopting a claimant-centred approach, as it suggests that claimants should be given enough information to be able to make an educated decision about their rehabilitation plan and that claimant preference should be taken into consideration and shared decision making should be encouraged. Respecting and valuing the claimant's views and opinions is critical to succeeding in this.

4. Shared knowledge and the free flow of information

Communication and multi-disciplinary working are key themes described in this report and they are the crucial in sharing knowledge and maintaining a free flow of information. The free flow of information should include open communication between health providers, ACC and the claimant if it is to be most effective.

5. Evidence-based decision making

Claimant rehabilitation plans should be based on the best available knowledge. Whilst health providers should take responsibility for this in ensuring their recommendations for treatment and rehabilitation are evidence-based, it is also important that the ACC ensure health providers have all the necessary information to do this (e.g. case conferencing provides a forum for sharing information that can ensure all health providers are aware of what the other is doing to ensure an evidence-based structured rehabilitation plan can be developed). ACC also has the responsibility to interpret the recommendations made by health providers and ensure an evidence-based plan is developed from them.

6. Safety as a system property

This rule suggests that it is a care systems responsibility to ensure the patient is safe from harm whilst under their care. Likewise, it is ACC's responsibility to ensure that the claimants are safe from harm while they are under ACC's care. For example, in ACC's current system claimants are often obliged to take part in the services they are referred to or risk losing their compensation. Therefore ACC has the responsibility to ensure the referrals they make are appropriate.

7. The need for transparency

It is important that claimants are kept up to date with what is happening with regard to their rehabilitation plan and ACC. This is an important overarching theme that has been covered in several of the recommendations above.

8. Anticipation of needs

The rule highlights the importance of being proactive rather than reactive in healthcare. This is also important advice for ACC. Being proactive and anticipating the claimant's needs is more likely to result in sustained positive outcomes.

9. Continuous decrease in waste

In this rule the committee suggest that the 'system should not waste resources or patient time'. In ACC, it is important that the processes and structures support and foster rehabilitation plans respondent to claimant's needs, rather than simply responding to key performance indicators. If rehabilitation plans are designed in collaboration with the claimant and health providers, it is more likely that the rehabilitation plan will result in positive outcomes and less likely to result in failed interventions which cost both ACC and the claimant in time and money.

10. Cooperation among clinicians

This rule clearly links with the recommendations made above that multidisciplinary working should be standard procedure within ACC.

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