

The Evidence (and Ecology) of RTW Rehabilitation

A model of rehabilitation and early intervention
case management

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Outline

- **The Evidence-base**
 - Inclusive approach to evidence in rehabilitation: integrative synthesis
 - Gaps in knowledge identified
- **The Intervention**
 - A case example of early identification and management of psychological injury
 - Structure, process and outcome: qualitative evidence statements
- **The Implementation and Innovation**
 - Organisational tolerance and context
 - Achieving innovation
- **Summary and questions**

Acknowledgements

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The Evidence-base

- Rehabilitation lacks a sound evidence base, particularly in relation to return to work predictors and processes for implementation
- The evidence base (therefore best-practice) is constrained by lack of appropriate theory, heterogenous samples and settings, definitional variations and overly strict interpretations of evidence itself
- An integrative approach to evidence development is essential for the developing discipline of rehabilitation and informing interventions

The Evidence-base

- An **integrative synthesis** of return to work rehabilitation predictors was conducted
- Focus on musculoskeletal injury group as the most prevalent injury type and research quantum
- Systematic review of qualitative and quantitative literature and expert review

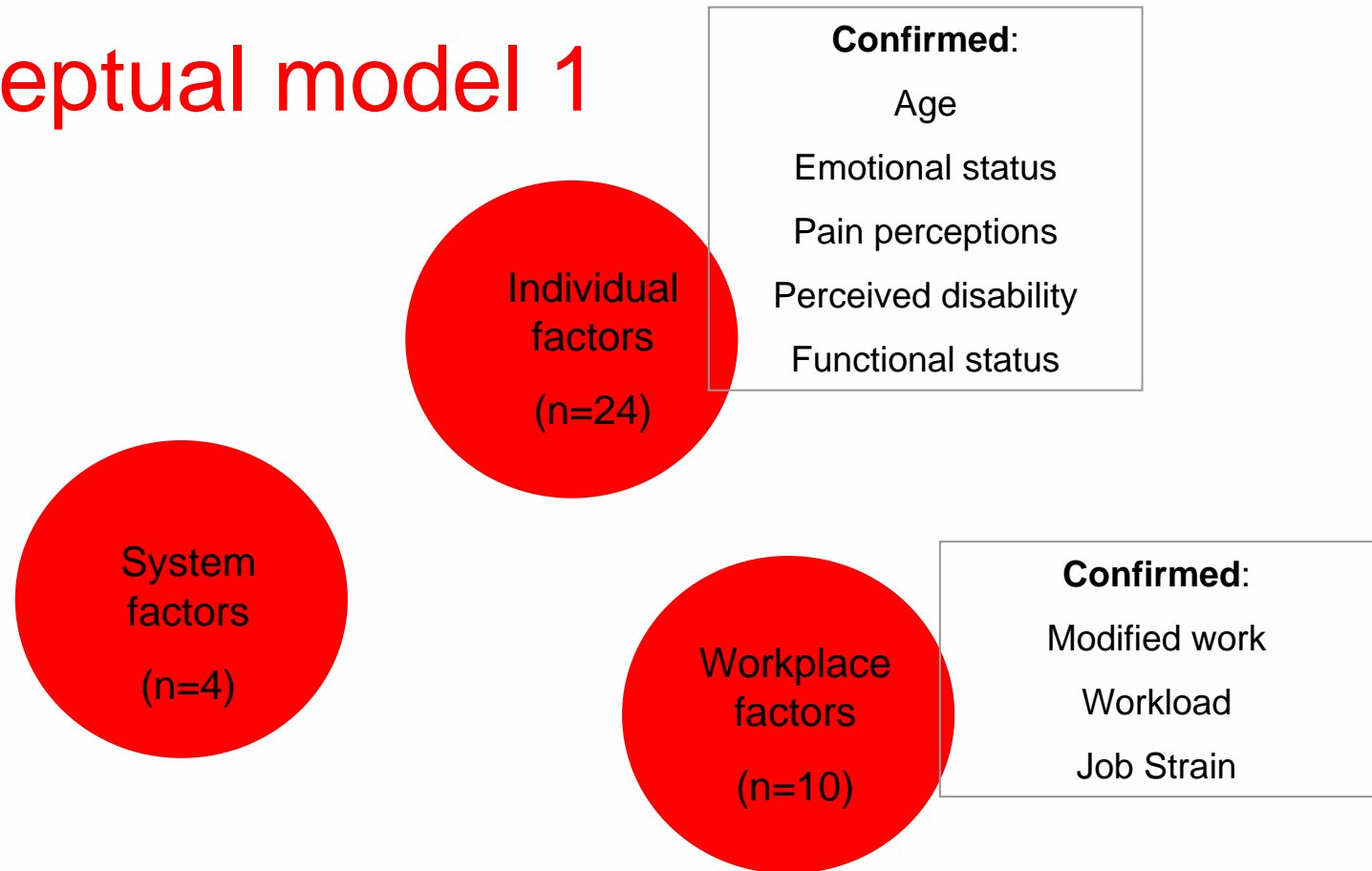
Review of quantitative research

- Highlighted the collective contribution of factor domains, but not their interactions
- Disconfirmed the significance of individual factors commonly included in research (gender, marital status, injury severity)
- Highlighted gaps in knowledge relating to workplace related factors (i.e., managerial support, rehabilitation processes)
- Confirmed the importance of subjective factors (i.e., perceived disability, expected rtw)
- Caveat: limited research in these areas restricts conclusions, but trends evident

Review of quantitative research

- Systematic review of electronic databases: n=1381 studies
- Total studies selected for review: n=55
- Quality scoring (/7)
 - High quality=32%
 - Mod quality=58%
 - Low quality=7%
- Number of unique factors identified: n=38
- 3 domains: individual, workplace, system

Conceptual model 1



Review of Quantitative Research

- BUT, factors were too broadly defined and multi-dimensional, underestimating potential for factor contribution in practice
- Need for clinician perspective as a valued source of evidence
- Time-consuming, but critical for developing the new knowledge base
- Lack of innovative methods to incorporate expert opinion in research

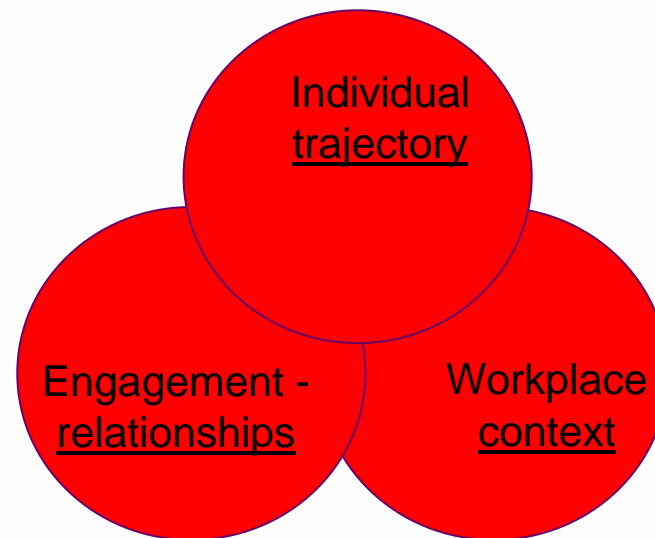
Expert review

- Incorporating a sample of clinician perspectives (n=12) using a mixed methods approach (qual, quant)
- See *Muenchberger, Kendall & Gee (2008) JOOR*
- Expanded set of 85 predictors agreed upon
- AIM: To determine importance, modifiability, rationale and classification type of factors by clinicians (Krause et al., 2001)
- Only 4 / 85 factors **important AND modifiable** (i.e., focus for rehab)
- Settings-based, GP-worker partnership, Goal orientation, Timeliness

Expert review

- Confirmed an inter-relationship between factors
- Highlighted the centrality of supportive processes
 - Time (recovery trajectory)
 - Context (workplace setting, org support)
 - Engagement (relationships)
- Caveat: limited expert sample: difficult to generalise but more high quality research is needed in these areas

Conceptual model 2



Confirmed:

Timeliness

Clear goals

GP and worker
communication

Work-place based

Proactive response

Modified work

Workplace accommodations

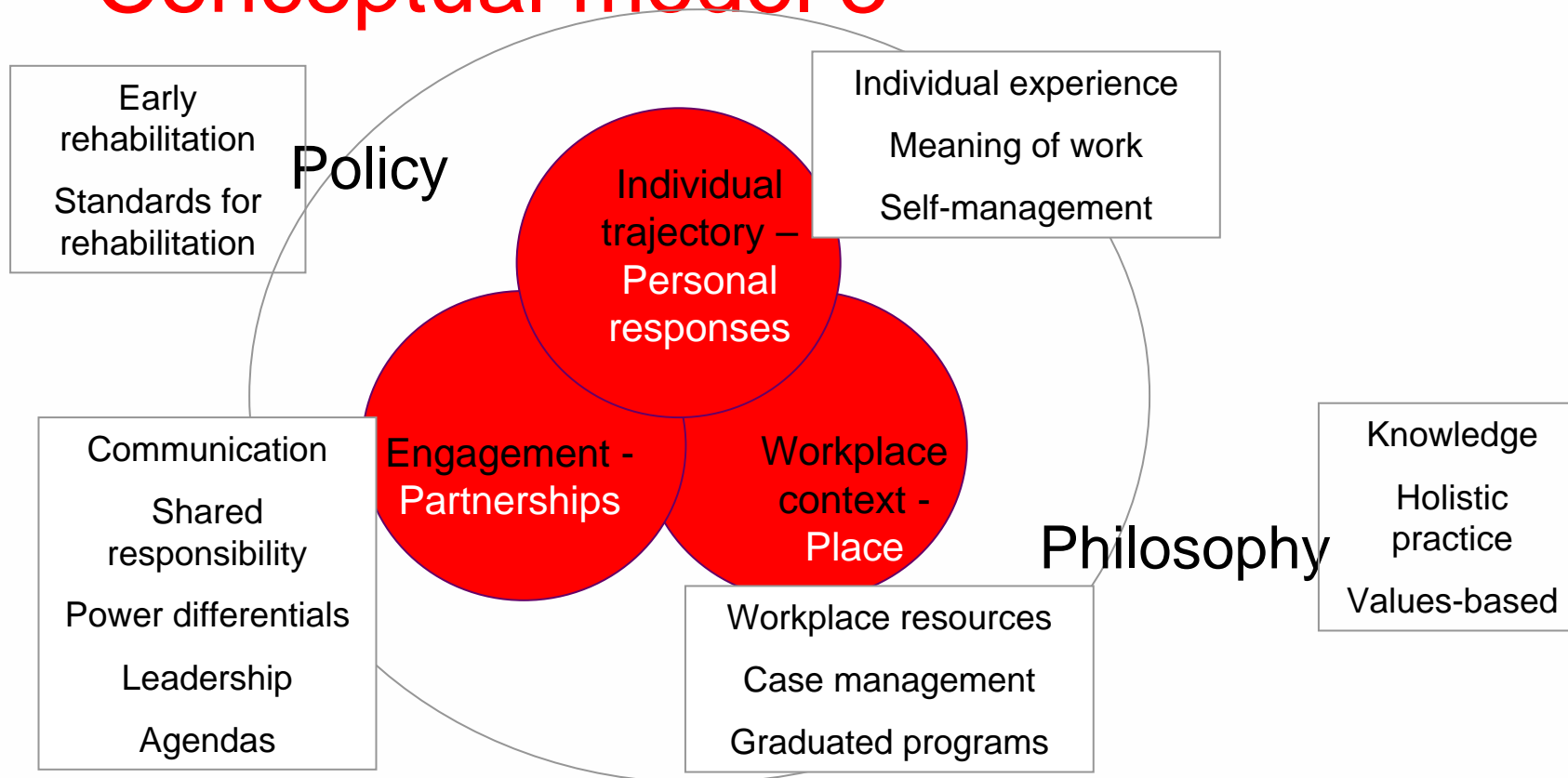
Intensity of rehabilitation

Review of Qualitative Research

- Meta-ethnography (n=88 studies)
- AIM: To clarify the nature of the rehabilitation ENVIRONMENT
- Confirmed 5 key components of a Rehabilitation system
- Partnerships are central to outcomes



Conceptual model 3



The Integrative Synthesis

Rehabilitation best practice involves:

- the collective contribution of individual, workplace and systemic factors
- complex processes rather than static factors
- subjective factors and place-based factors: how these ‘fit’ together
- 5 core components for systemic change
- evaluative research and gathering of new knowledge from a variety of sources: “capture the dimensions of humanity” (Clarke, 1999)

Evidence statement #1

The existing research tells us that true rehabilitation is a supportive and collaborative process, the outcomes of which are dependent upon its timeliness and responsiveness to change, its attentiveness to the workplace context and the extent to which stakeholders are engaged in a process that is centred on motivating the injured worker.

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The Intervention

- Evidence suggests that interventions need to focus on a series of inter-dependent processes and interactions that enhance self-determination and control over their work
- A process-oriented model: structures alone are insufficient
- Based on strength-base case management model (solution-focused, strengths and talents of worker)
- CM=Not one-size fits all approach: dependent on population / place factors.

The Intensive Case Management Model : A Case Example

- The Intensive Case Management Model: **whole-of-government** stress management response (Dept of Industrial Relations, Qld)
- Based on a report by *Kendall, Muenchberger & Murphy (2005) DIR Report*
- Ref: *Muenchberger, Kendall, Domalewski et al. (2006) IJDMR*
- PURPOSE: to facilitate the delivery of timely intervention by external providers to coordinate an early and sustainable return to work
- GOAL: to effectively manage psychological injury at work and simultaneously reduce the incidence of WorkCover claims

The Intensive Case Management Model : A Case Example

- Key components
 - 5 key stages
 - Funding structure (max of 15 hours and up to \$2000 ICM)
 - Identified network of external service providers
 - Early referral process
 - Time limited and outcome driven
 - Relationship-based, team approach

The Intensive Case Management Model : A Case Example

- The 5 key process points and example milestones:
 - Pre-referral process
 - (identification of IW)
 - Referral process
 - (notification and introduction)
 - Assessment
 - (contact of IW /Provider <48hrs, Ax <5 days)
 - Intervention and reporting processes
 - (ICM within 15hr, case conference <25days of referral, rtw plan)
 - Closure processes
 - (report <5 days of case conference)

The Intensive Case Management Model : A Case Example

Research rationale:

- To understand the **structure, process and outcomes** of the implementation by organisations
- Key components can act as key principles for similar initiatives

The Intensive Case Management Model : A Case Example

- **Methodology**
 - Focus groups: semi-structured
 - Individual Interviews
 - Participants
 - Employers (n=12 govt departments, 15 participants)
 - Providers (n=3 service providers, 4 participants)
 - Procedure: focus groups and telephone interviews :
transcribed verbatim and followed qualitative analysis methods
(Coffey and Atkinson, 1996)
 - Three independent researchers, consensus process

The Intensive Case Management Model :

KEY LEARNINGS

- Structure - Funding
 - Funding structure: up to 15 hours of intervention at a maximum cost of \$2000 per worker. Negotiation of additional services if warranted. (Sponsored by the Qld State Govt)
 - Evidence statement #2: For the ICM study, funding was reasonable, particularly for immediate cases where early identification and action was possible

The Intensive Case Management Model :

- Structure - Funding
 - The payment structure enabled employers to monitor the quality of the intervention
 - “I only pay for the hours used, and the service provider will actually do a delivery plan if you ask them, that sets out your costs and hours for intervention” (Employer)
 - Smaller external providers spent many more hours to ensure handover and communication in place

The Intensive Case Management Model :

- Structure - Funding
 - Limitations when dealing with complex cases and rural/remote cases
 - “I suggest it needs more hours and more consideration of payment – in some cases it may be superficial” (Employer)
 - “we will absorb the costs of rural and remote services – we are trying to establish networks in those regions, but it takes a special breed” (Provider)

The Intensive Case Management Model :

- Structure - Funding
 - Alternative providers were accessed: rather than providing the upper limit of \$2000, an employer requested initial Ax and costing for each worker. This meant fewer hours at a lower rate, but complex cases required increased hours.
 - Many employers only focused on early intervention of recently injured workers, but some chose to “clean up a backlog of cases” to determine ICM client list at greater cost/time.

The Intensive Case Management Model :

- Structure – External providers
 - Official list of external providers provided under the ICM
 - Evidence statement #3 – Utilisation of external providers was beneficial in most situations. External providers were seen to have credibility and bring an unbiased perspective to the situation. Their utility was influenced by the lack of stability of provider personnel and paucity of suitably qualified practitioners

The Intensive Case Management Model :

- Structure – External providers
 - External providers found the ICM model allowed for a balanced and independent approach, enhancing acceptability and credibility
 - “I like the providers to facilitate the process as they are an independent person, we find the venting stuff usually gets done during the initial assessment, the provider will review what to expect in the case conference (no surprises) and they communicate any problems anticipated” (Employer)

The Intensive Case Management Model

- Structure – External providers
 - Using external providers enabled employers to selectively recruit providers with specialist skills (e.g., conflict resolution) and that were familiar with the workplace context
 - “I use [provider] for all psychological claims and one for other claims – one knows our physical work context well and the other knows our office politics”
 - However, additional time was required to develop this knowledge base
 - “I think you get a really good outcome with a provider if you put the hard yards in first to establish everything.

The Intensive Case Management Model :

- Structure – External providers
 - Providers agreed that understanding the work context was crucial
 - “It is really important for us to develop a good relationship with everyone – then we can make recommendations that are appropriate rather than saying ‘you should do this’ when the culture will not allow this to occur. It is a matter of developing intimacy not just with [clients] but within the culture they are operating” (Provider)
 - A major challenge was lack of consistency of external providers: there was a need for continuity of provider
 - “the change of staff in provider agencies has created time lags and the need to go over ground already covered” (Employer)

The Intensive Case Management Model :

- Structure – External providers
 - Smaller providers offered greater personnel stability, but they were limited in their capacity to accept referrals
 - “my concern is that we are running them [providers] very thin – we are all using only a few providers and they only have a few staff”
 - Smaller providers were more flexible in their capacity to facilitate and accommodate complex cases
 - Lack of services in rural areas jeopardised the success of the ICM model
 - “being able to get providers in the more rural areas has been a a real problem for us – it can take days or even weeks to arrange suitable services in these areas, which holds up the process, and momentum can be lost”

The Intensive Case Management Model :

- Structure – Existing organisational frameworks
 - Need to compliment existing initiatives within the organisation
 - The level of organisational tolerance and receptiveness
 - The promotion of the ICM model in the workplace

The Intensive Case Management Model :

- Structure – Existing organisational frameworks
 - Need to compliment existing initiatives within the organisation
 - The more integrated the program, the more likely it was seen to be a solution, Employers stated:
 - “the ICM was a perfect framework to hang everything else on”
 - “in our department, the ICM forms one package, and we have linked it to our rehabilitation area, our health and safety area, and wellness committees – those all form one unit
 - Employers saw value in using the ICM model as a central framework to promote effective injury management
 - “ICM has been promoted around management groups and several programs have been developed than can support ICM – we have developed some systems around the ICM for injury identification and people management – it has enabled us to go forward with injury prevention” (Employer)

The Intensive Case Management Model :

- Structure – Existing organisational frameworks
 - Level of organisational tolerance and receptiveness
 - “it [success] has to do with the commitment of those at the coalface, especially the employers – if they see the ICM as a threat or say ‘I have got my own processes and have been doing this for decades then you just do not get them on board” (Provider)
 - “Managers and supervisors are crucial to get on side – we need to convince them about what to do to promote ICM – if we do not do this then we will be talking to injured workers months down the line” (Employer)

The Intensive Case Management Model :

- Structure – Existing organisational frameworks
 - Organisational promotion of the ICM
 - Strategies to promote the model varied among stakeholders
 - Some developed brochures to inform staff and raise awareness of the benefits of reporting psychological injury
 - Others informed workers by way of information sessions and newsletters
 - Others approached management to increase their awareness and support of the ICM
 - Marketing strategies did “not necessary refer to the ICM as a 15 hour model or even case management”...

The Intensive Case Management Model :

- Structure – Existing organisational frameworks
 - Culture considerations:
 - A hierarchical system: entrenched behaviours top-down
 - An entitlement system: sick leave is a fundamental right
 - Evidence statement #4: The context of the organisation has a critical role in the acceptance and implementation of new initiatives. Without consideration of the context, the intervention is likely to be undermined. Change takes time, and the integration of the ICM into existing frameworks/ philosophies and policies appears to have been palatable to most organisations.

The Intensive Case Management Model :

- Processes – Early and concise referral processes
 - Evidence statement #5: despite the lack of suitability of the ICM for long term complex cases, it was found to have some utility. In the absence of something more appropriate, employers used the ICM to address issues with long term entrenched cases, and although limitations were recognised, they were surprised at the results.

The Intensive Case Management Model :

- Processes – Early and concise referral processes
 - Some employers utilised OHS staff to identify referees, while others trained supervisors and managers
 - “Most of our referrals come from our regional people, our health and safety people on the ground. Normally they phone me or see a project officer to find out if this person will be suitable to be referred into the early intervention program.” (Employer)\
 - Employers also established a gatekeeper role by determining set referral criteria
 - “Our organisational Health Leader Team makes referrals to our department...we think about whether ICM would work, the ICM process is voluntary and dependent on likelihood of claim, work related injury, or absence of work likely, or workplace dysfunction”

The Intensive Case Management Model :

- Processes – Early and concise referral processes
 - Reluctance to utilise external providers – keeping it “in house”
 - Variation in referral processes and start times for different cases:
 - “while the outline of the model was clear, I don’t think the departments implemented appropriate referrals. For example, in one department a lot of the referrals were ‘stuck cases’, very complex entrenched behaviours, relationships have disintegrated...the referral process in these cases is a barrier, because when you saw the client there wasn’t a lot you could do in the short time frame” (Provider)

The Intensive Case Management Model :

- Processes - Adherence to specified timeframes
 - Evidence statement #6: although the timeframes of the ICM were useful in that they ensured timely action and feedback, the utility of these timeframes was questioned regarding complex and long standing issues. Given the nature of psychological injury at work and the likelihood of delays in reporting such injuries, it was determined that the time periods were artificial in many instances. Flexibility was required from providers, employers and injured workers.

The Intensive Case Management Model :

- Processes - Adherence to specified timeframes
 - Consensus that a model based on clearly specified and tight timeframes was valuable

“it is really good because it means you have to get it done...ICM is one of the things you don't put off..I think it will force you to come up with the formulation and the plan..it forces you to liaise and come up with the stuff you should be doing anyway”
 - Timeframes were inappropriate in some cases
 - “sometimes you have to be practical with a client – and you really have to say to the client that you have to move on and do something else and to develop some coping strategies”
(Provider)

The Intensive Case Management Model :

- Processes – Collaboration among the team
 - Evidence statement #7: the ICM model facilitates receptiveness and responsibility of stakeholders and increases awareness regarding barriers of return to work. Maintaining professional boundaries was important, as was fostering support at various levels of the organisation.

The Intensive Case Management Model :

- Processes – Collaboration among the team
 - The model enforced collaboration, usually among the employer, provider, employee and the GP.
 - GPs maintained a gatekeeper role according to some: they were likely to safeguard their patient and recommended extended periods away from work.
 - “our [concern] is the GP...they were just giving injured workers three months absence without consulting us...our ICM provider made appointments with the GP, sat down and discussed it all, a graduated return would get them back in three weeks” (Provider)
 - “the GP believed it was too early or too late – he felt the client needed to be well enough to face the issues in the workplace”

The Intensive Case Management Model :

- Processes – Collaboration among the team
 - Establishing boundaries was important, and distinguishing between ICM and ongoing case management and ICM and treatment was acknowledged.
 - Communication was crucial to the success of the model
 - “everybody should understand their responsibility and that’s what makes ICM work – ICM gives me the opportunity to say ‘Look you have a problem, lets talk about it’” (Provider)
 - No surprises policy for case conference encouraged trust
 - Straightforward reporting with strategies was important
 - Managerial support: the ICM was a considered a training tool to prompt injury reporting processes and planning next steps.

The Intensive Case Management Model :

- Outcomes – ICM impact
 - Influenced incidence of claim lodgement, reduced time absent from work and facilitated a successful return to work
 - The model was perceived to be a promising cost containment tool
 - The structure and processes provided the impetus for change
 - It provided a safe environment that enforced reporting and identification of psychological injury at work
 - The model was frequently used as a risk assessment tool, screening tool and education tool
 - The model was used to provide a framework for motivating and delivering a system of injury management within the organisation

The Intensive Case Management Model :

- Outcomes – ICM impact: Employers
 - “It [ICM] has a large bearing on absenteeism and [keeps workers] away from WorkCover – we had two instances where people have put in a claim, we put the provider on it straight away and within three days those people withdrew their claim”
 - “over 50% of cases who were following the ICM model did not result in a WorkCover claim”
 - “we sent five cases to [provider] and none of them lodged a claim”
 - “If we can get them before they lodged a claim, chances are they won’t”
 - We used to be dealing with over 30 stress claims and now we are dealing with only about 7 [since implementing ICM].

The Intensive Case Management Model :

- Outcomes – Unintended outcomes
 - Created a **secure environment** for the identification of people at risk and facilitated the reporting of stress
 - Preserved the **safety of all parties** and provided opportunities for managers to learn about psychological injury in a supported context
 - The model encouraged managers to **address problematic leadership behaviours** without fear: educative leadership programs
 - Use of the model to **initiate workplace mediation** practices (documentation of the problem by the independent expert, collaborative process leading to case conference, development of agreed strategies)
 - Use of the model to determine a **clearer picture of IW concerns**

The Intensive Case Management Model :

- Outcomes – Unintended outcomes
 - **Risk management tool** – by providing the employer with an ongoing source of information about how stress was experienced within their workforce and the issues that may require attention. As a result of the ICM, employers had engaged the providers in the delivery of stress awareness programs of various kinds.
 - The model encouraged **employers to engage** with providers, rather than trying to handle difficult situations alone
 - **Realistic assessment** of a return to work option, or not
 - The **identification of medical conditions**, and action plan for employees with severe mental illness who may often be overlooked and remain untreated – everyone knows what to do
 - Report recommendations were used as a **budgetary measure**

The Intensive Case Management Model :

- Key success factors
 - Ensures timeframes to prevent delays
 - Contained funding structure, giving employers more control
 - Collaborative case conference
 - Use of external skilled providers
- Limitations of the model
 - Early identification: how early is early? Education, culture, peer support identification programs
 - Time limited versus time monitored
 - Sustainability of the agreement/action plan
 - Limited follow up: maintaining links post-case conference
 - Resource demands: centralised funding, capacity of providers
 - Flexibility of the model: ability to exit and re-enter the model
 - Regionalisation and rural issues

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The Implementation

- Interventions may fail because of lack of understanding of the implementation process, not the intervention itself: Type III error
- Refer to: Greenhalgh et al., (2004) for an excellent review

Implementation Research

- Future intervention research should consider:
 - Theory-driven, evidence-based approaches
 - Process rather than package oriented
 - Ecological: reciprocal interactions between the program and place
 - Standardised definitions, measures and tools
 - Collaborative and coordinated approaches
 - Multi-disciplinary and multi-method
 - Meticulously detailed
 - Participatory action research models

The Innovation

- Need to understand how service interventions can become system innovations:
- Link evidence with practice, and consider broader environmental, sociological and management context

Greenhalgh et al. (2004) Considerations for Innovative Systems Change

- **System antecedents for innovation**: structure, absorptive capacity and receptive context
- **System readiness for innovation**: tensions for change
- **Adopter and assimilation qualities**: needs, values, goals
- **Implementation processes**: decision making, hands-on, communication, collaboration, feedback
- **Linkage capacity**: in design and implementation stages
- **Inner context / Outer context**: sociopolitical climate, norms
- **Knowledge transfer** – diffusion to dissemination
- **Innovation processes**: trialability, relative advantage, potential for reinvention, fuzzy boundaries/solid core.

Thankyou

