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Provider Engagement Team

WorkCover Queensland

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FPM response to WorkCover Queensland Recovery & Rehabilitation Standards

The Faculty of Pain Medicine (FPM) of the Australian and New Zealand College of Anaesthetists is pleased to offer a submission to WorkCover Queensland regarding the proposed *Recovery and Rehabilitation Standards*. FPM is the peak body for the training, continuing education and maintenance of standards for specialist pain medicine physicians across Australia and New Zealand. Fellows of FPM are super-specialists who already hold qualifications across a range of medical disciplines prior to their commencement of training with FPM. This submission has been authored by a group of pain medicine physicians with wide experience in the management of occupational injuries and with specific input from fellows practicing in Queensland.

To address the specific areas of enquiry outlined in the accompanying consultation paper, FPM offers the following comments:

Clinical and rehabilitation practice

Do the standards reflect contemporary evidence and accepted professional practice?

This is partly the case, but the standards appear to have a relatively unfocused interpretation of the concept of rehabilitation and there needs to be clearer recognition of the complex factors that can lead to poor outcomes in the treatment of injured workers.

Are there any principles that require clarification or amendment?

The concept of rehabilitation, as applied, is too broad. Much rehabilitation in injured workers is very straightforward and general experience from across Australian workers' compensation schemes is that the overwhelming majority of injured workers (80% or more) return to their normal working role, or something close to it, within 12 months. It is the residuum, often identified as so-called "tail claims", that understandably cause the most concern and where simple concepts of rehabilitation fail.

Are there any important elements of good rehabilitation practice that are not currently reflected?

In the view of FPM, the standards do not reflect the nature of specific interventions that need to take place in rehabilitation where chronic pain is the driving cause of disability. This will represent a non-trivial proportion of long-term claims and it is an area where specific processes of pain management are essential as part of the rehabilitation and functional restoration process.

Additionally, there are useful methods of determining risk at an early stage that are not referenced in the document. Whilst outcome measures relating to treatment have been highlighted, the important role of screening measures, with appropriate direction to services with specific skill sets, should be considered.

Practical application***Are the standards realistic and achievable in day-to-day practice?***

A strength of the standards is the general clarity relating to process application. In many cases, the standards will be fully achievable in regular practice. However, there are many factors that can lead to failed occupational rehabilitation.

The broad concept of “biopsychosocial” approaches is reasonable, but a mistake that is often made in these circumstances is an underappreciation that the construction of this word encompasses three very separate areas of influence over the presentation of injury and subsequent rehabilitation needs. In particular, psychological and social factors are often lumped together with reference to “*psychosocial factors*”.

Psychological and social factors can indeed be related, but they are quite different. This means that attempting to deal with difficult social circumstances is often something that is delegated in a broad fashion to mental health disciplines and there is little evidence that this is particularly useful.

The most significant social factor within work-related injuries is the influence of the work environment. In this respect, although the standards acknowledge employer involvement, they do not adequately specify employers’ responsibilities or arrangements for liaison between employers and treatment providers. This itself makes the broad aim of the standards potentially difficult to achieve in some circumstances.

Could any aspects create unintended administrative burden or barriers to care?

By themselves, the standards should not result in any such barriers arising. However, what the standards do not address is current, existing administrative burdens, particularly relating to appropriate treatment access. For example, the standards make no reference to the use of independent medical examinations in directing treatment. Whilst it is certainly the case that in some circumstances, independent medical examinations are reasonable, there are other circumstances (and this is well recognised in legal circles) where such examinations are used as a form of gatekeeping practice. This is questionable from both an ethical and a legal viewpoint, and furthermore it potentially conflicts with the specified standard relating to trauma-informed care. This is an important consideration in long-term claims where the overall stress of administrative processes can become a serious problem for injured workers.

Are there circumstances where greater flexibility may be required?

There are, potentially, many circumstances where greater flexibility may be needed. In particular, in uncommon but serious pain conditions such as complex regional pain syndrome (CRPS), progress is often slow and recovery is incomplete. This causes great distress to injured workers and it should not be the case that the slow recovery is interpreted as evidence of either poor cooperation from the injured worker or failed treatment on the part of the practitioner.

There are many other examples, but it is important that claims managers and rehabilitation coordinators are well-educated about the nature of such conditions.

Current Australian data suggests that claims managers in the workers compensation industry often have a high caseload and there is a substantial turnover. In this respect, it is important that claims

staff are well-educated in the nature of conditions that might see a divergence from a normal occupational rehabilitation process.

Worker outcomes

Do the standards support recovery, function and safe, sustainable return to work?

Broadly speaking, the standards as outlined are supportive of such processes. They will be appropriate to the great majority of injured workers. The difficulty arises where processes deviate from expected paths.

Are there any risks that the standards could unintentionally impact worker outcomes?

Again, for the great majority of injured workers, this will not be the case. However, there are exceptions to this and as noted earlier, the lack of visibility of employer accountability within the standards together with injudicious use of processes such as independent medical examinations within this framework could have a negative impact on outcomes for injured workers.

Implementation

What guidance, resources or education would assist providers in applying the standards?

As is always the case, appropriate education forums would be helpful. However, the forums should be interactive and, in particular, critical but constructive commentary should be encouraged. Additionally, it would seem equally important to organise forums to allow appropriate education of claims staff, particularly with respect to some less familiar clinical scenarios that tend to cause significant concern. In particular, specific education on uncommon pain conditions such as complex regional pain syndrome will be important.

Are there profession-specific considerations that should be recognised during implementation?

Where pain-related disability and associated work limitation occur, recognition should be given to appropriate multidisciplinary and interdisciplinary care provided by persons with defined expertise in the area. Specialist pain medicine physicians have well-documented expertise in this field and additionally, the role of medically-led interdisciplinary care teams should be recognised as an important part of functional restoration in such scenarios.

Summary

FPM supports the proposed standards' emphasis on person-centred care and understands the overall priority of achieving a safe and sustainable return to work. However, the current standards appear to be framed at a general level and, noting earlier comments in this submission, functional restoration works well for the great majority of injured workers supported by workers compensation schemes. Our concerns relate to how the standards might be applied to claims in which persistent pain and other chronic conditions, most notably mental health conditions, result in delayed or incomplete recovery. In such situations, a multidisciplinary approach is likely to be the only intervention with any reasonable chance of success and the standards do not clearly identify this as a preferred treatment pathway. Indeed, the standards' suggestion of one primary provider being the key individual responsible for supervising treatment may work directly against the aims of multidisciplinary or interdisciplinary care.

FPM also recommends that the standards clearly distinguish rehabilitation from pain management whilst, simultaneously, recognising that in many circumstances rehabilitation will be critically dependent on effective pain management.

As noted in previous comments, the employer's active participation in any rehabilitation process should be clearly identified. In many situations, work can be considered to be an appropriate form of therapy, but where this is not supported by employers' engagement with a return-to-work process, it becomes unreasonable to suggest that failure of progress is due to ineffective treatment.

The standards identify that early identification of potentially problematic cases is important. However, it is equally important to understand that effective interventions do exist in this setting and, again, much of the supportive literature in this area has been published within the pain management sphere.

Finally, the standards, as published, do not outline how they were conceived and realised. It will be helpful for WorkCover Queensland to publish the process and thinking behind the standards, together with the evidence base that was used to support it. This would reassure key stakeholders, notably injured workers and employers, together with providers involved in the rehabilitation process, as to the overall integrity of the standards' development pathway.

Please do not hesitate to contact me at the Faculty of Pain Medicine if you wish to discuss any aspect of this submission.

Yours faithfully,



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