

Clinical framework for the delivery of physiotherapy services to injured workers

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These clinical guidelines were developed in collaboration with WorkCoverSA's Physiotherapy Reference Group. All members of the group are members of the Australian Physiotherapy Association (APA).

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Whilst every effort has been made to ensure the accuracy and completeness of this framework, the advice contained herein may not apply in every circumstance. Accordingly, WorkCover cannot be held responsible, and extends no warranties as to:

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- actions taken by third parties as a result of information contained in the Clinical framework for the delivery of physiotherapy services to injured workers.

Foreword

The WorkCoverSA *Clinical framework for the delivery of physiotherapy services to injured workers* (the *Clinical framework*) reflects the most contemporary approach to physiotherapy management of injured workers.

The Clinical framework outlines a set of seven guiding principles and is based on best available evidence, consensus clinical opinion and the belief and value of injured workers.

Through representation on the Physiotherapy Reference Group (a collaborative group between the APA SA Branch and WorkCoverSA), the APA made significant contributions to the development and implementation of this quality support system for physiotherapists.

We would like to acknowledge the following individuals and groups who have contributed to the development of the framework:

- WorkCoverSA Physiotherapy Advisory Panel – Alison Bell, Martin Van Der Linden, Jenny Geytenbeek, Janet Baines, Carolyn Berryman and John Vieceli.
- Australian Physiotherapy Association SA Branch

On behalf of the APA SA Branch and WorkCoverSA we encourage you to apply these principles to your practices to ensure timely, safe and durable stay at work and return to work outcomes for injured workers.



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Our vision

Best possible recovery, faster return to work.

Our mission

WorkCover is funded by employers to manage a balanced and financially sound system that rehabilitates, compensates and returns injured workers to safe workplaces and the community.

Purpose

The Clinical framework has been established to:

- optimise return to work outcomes
- inform physiotherapists of WorkCover's expectations for the management of injured workers
- provide a set of guiding principles for the provision of physiotherapy services for workers, physiotherapists, other health professionals and WorkCover claims agents
- facilitate providers to implement best practice when managing injured workers.

The *Clinical framework for the delivery of health services* is the broader overarching document that outlines a set of five principles to guide the delivery of health services and support allied health professionals, including physiotherapists, in their management of injured workers.

The *Clinical framework for the delivery of physiotherapy services to injured workers*, whilst aligned to this overarching document, provides physiotherapists with more specific and comprehensive guidance on seven framework principles to support and ensure the delivery of outcome focused physiotherapy management.

Information about the *Clinical framework for the delivery of health services* and the *Clinical framework for the delivery of physiotherapy services to injured workers* can be found on the WorkCover website at www.workcover.com.

Aims and principles

The Clinical framework aims to optimise the injured worker's safe and prompt return to work. Underpinning this aim is a set of principles for the provision of physiotherapy services to injured workers:

- 1. Measurable physiotherapy management effectiveness should be demonstrated.**
- 2. A biopsychosocial approach is essential for the management of pain.**
- 3. Physiotherapy management should facilitate development of worker self-management strategies.**
- 4. Goals of physiotherapy management should be functional and focused on return to work.**
- 5. Physiotherapy management should integrate the best available research evidence with clinical expertise and patient values.**
- 6. Communication between professionals involved in a worker's rehabilitation will optimise outcome.**
- 7. Physiotherapy management should cease once attainment of optimal outcome has been achieved.**

Application

This document applies solely to the provision of physiotherapy services to workers within the South Australian Workers Rehabilitation and Compensation Scheme under the *Workers Rehabilitation and Compensation Act 1986*.

WorkCover will work in consultation with all physiotherapists within the South Australian Workers Rehabilitation and Compensation Scheme to promote and apply the principles of the (*Clinical framework* in the delivery of physiotherapy services to injured workers.)

Principle one

Measurable physiotherapy management effectiveness should be demonstrated

Key messages

1. Management effectiveness should be demonstrated using outcome measures.
2. When available, use outcome measures that are:
 - reliable, valid and sensitive to change
 - related to the functional goals of management
 - based on impairment, activity and participation domains
 - relevant to the worker's injury.

Measurement of management effectiveness (outcomes) provides workers, physiotherapists, WorkCover and its claims agents with information on the rate (and direction) of change. An outcome measure is a tool that attempts to define assessment findings in a robust manner. For example, is the worker's function improving, worsening or not changing? This information assists all parties to justify their decisions to continue or change the physiotherapy management plan, cease treatment or refer the worker to another health professional.

What outcome measure to use

Management effectiveness should be measured with one or more standardised outcome measurement tools. The chosen tool should be reliable, valid and sensitive to change. At times, physiotherapists may use customised outcome measures in situations where standardised measures are not available.

Outcome measures must be related to the functional goals of therapy and cover the World Health Organisation (WHO) International Classification of Functioning (ICF). Clinical

measures such as range of motion, manually tested muscle strength, soft tissue length, numerically rated pain score etc. may be used to track changes within a treatment session and assist in a physiotherapist's clinical reasoning process. However, since they do not reflect the injured worker's activity limitations, work capacity or participation restrictions, impairment measures should not be used in isolation.

How to record

Outcome measures can be recorded as part of keeping accurate case notes on a separate summary sheet if preferred. An example of this (treatment goals and outcome measures) is included as Appendix one, page 12. Outcome measures need to be easy to access and compare, and therefore a summary sheet often facilitates this process.

Another useful tool is an outcome calculator. A calculator developed by the Centre for Allied Health Evidence, University of South Australia, is available for purchase at <http://www.unisa.edu.au/cahe/>

When to measure

Outcome measurements need to be taken regularly to measure the rate and direction of change in the worker's status. Baseline measurements should be taken prior to commencing treatment, or as early as possible. Re-testing should occur as soon as change could be expected given the worker's injury and the type of treatment provided (e.g. one week for acute injuries or several weeks for chronic conditions). Regular use of outcome measures provides ongoing information about the worker's status and the

Table 1: WHO ICF domains with examples of outcome measurement tools

Functioning and disability	Examples of outcome measurement tools
Impairments (problems in body function or structure)	Range of motion (e.g. goniometer); muscle strength (e.g. dynamometer, manual muscle test); pain (e.g. 0-10 numerical scale, 10cm visual analogue scale, McGill Pain Questionnaire)
Activity limitations (difficulties an individual may have in executing activities) and participation restrictions (problems an individual may experience in involvement in life situations)	The Patient-Specific Functional Scale, Oswestry Disability Questionnaire (for low back pain), Neck Disability Index, Tampa Scale for Kinesiophobia, 6-minute walk test (SMWT) and Orebro Musculoskeletal Pain Screening Questionnaire. Further information about outcome measurement tools is available on WorkCover's website (www.workcover.com) and on the Chartered Society of Physiotherapists outcome measures database (www.csp.org.uk/)

Principle two

A biopsychosocial approach is essential for the management of pain

Key messages

1. **Physiotherapists should consider the psychosocial factors that influence the worker's experience of pain.**
2. **Acute injuries require treatment to minimise pain and enhance tissue healing while promoting early return to work and function.**
3. **Treatment for chronic pain must be based on a biopsychosocial approach, focusing on return to work and function, addressing underlying physical impairments and promoting self-management.**

From the outset of management, the physiotherapist should consider the psychosocial factors that can influence the worker's experience of pain.

Acute pain

After an acute injury, physiotherapy management focuses on minimising acute pain, enhancing tissue healing and promoting early return to work and normal functional activities. It is important, even in the early stages, to identify and manage presenting yellow flags. For information on yellow flags, please refer to the WorkCover website at www.workcover.com.

Chronic pain

Chronic pain is pain that has persisted for longer than three months. After this time, pain and impairment may persist due to the complex relationship between physical and psychosocial factors. Psychosocial factors (e.g. personality, psychological health, emotions, beliefs, feelings, education, past experiences and present environmental conditions) result in a set of cognitions and behaviours that affect the worker's pain experience.

Therefore, while pain may still be the worker's dominant symptom, it may not be appropriate to continue with treatment options aimed solely at local pain relief (e.g. electrotherapy or manual techniques). Physiotherapists need to consider all of the contributing factors when making management choices and their effectiveness for chronic pain.

These should include:

- adopting cognitive-behavioural interventions, which incorporate education, positive reinforcement, pacing and clear collaborative goal-setting. Often the involvement of the wider team of health service providers should be considered
- addressing physical impairments that may be contributing to the recalcitrant nature of the worker's pain such as abnormal muscle activity, restricted joint and soft tissue mobility, reduced neuro-motor control and deconditioning
- developing strategies to improve the ability of the worker to return to work and normal functional activities
- providing self-management support by:
 - » encouraging engagement in activities that promote good health
 - » facilitating the worker to monitor and manage signs and symptoms of the condition
 - » facilitating the worker to manage the impact of the condition on physical functioning, emotions and personal relationships
 - » facilitating the worker to negotiate and adhere to a management plan
 - » facilitating the worker to know their condition and the various physiotherapy management options.

It may also be appropriate to make recommendations to the worker's general practitioner about referring the worker to another health professional (such as a psychologist or psychiatrist), pain management clinic, alternative physiotherapy clinic or multidisciplinary team.

Flare-ups

Flare-ups of pain are common with chronic presentations and may occur at the same time as increased activity or stress. Physiotherapists need to educate workers to expect flare-ups of pain, and help them to realise that they are not necessarily an indication of further injury. It is important that the physiotherapist ensures that the worker is provided with a clear explanation of the relevant pain mechanisms (i.e. acute versus chronic pain). Flare-ups commonly occur in response to a graduated (functional) activity program, and the patient needs to see themselves working within a 'safe but sore' limit.

Principle three

Physiotherapy management should facilitate development of worker self-management strategies

Key messages

- 1. Information assists the worker to understand their injury and its management, make choices, overcome unhelpful beliefs and modify behavior.**
- 2. Assisting the worker to take control of their pain requires the use of active strategies such as:**
 - active rehabilitation focusing on functional activities
 - avoidance of regular, passive treatment techniques without evidence of ongoing effectiveness
 - educating the worker about their rehabilitation, the neurobiological basis of their symptoms, their involvement in improving outcomes and how to use this knowledge to take control of their symptoms.

Empowering the worker to be actively involved in their treatment is an important component of effective rehabilitation. This may be achieved through education and other strategies to assist the worker to take control of their injury or pain.

Education

Knowledge is integral to promote empowerment, and the physiotherapist should inform the worker about:

- their expected role in recovery
- their expected outcome
- their injury, the expected recovery pathway, treatment goals (short and long-term) and time frames to achieve their treatment goals (as outlined in Principle four)
- the impact of failed treatments (where appropriate) and proposed changes that may lead to a successful outcome for the current intervention.

Control

The worker needs to accept and take control of managing their symptoms. To assist them to do this, the physiotherapist needs to be aware of the variety of strategies that the worker may be using to cope with their symptoms. Broadly speaking, individuals may primarily use:

- active strategies, where they take some responsibility for their pain management,

or

- passive strategies, which involves withdrawal or assigning the responsibility for the control of pain to someone else. These strategies can be highly predictive of chronic impairment and pain. If an individual primarily uses passive coping strategies or if the treatment ceases to be effective, then passive, 'hands-on' treatments (such as manipulation, mobilisation and massage) may need to be limited or used sparingly, with the primary focus on education and an active management program. These passive strategies promote dependency and result in the worker perceiving that the physiotherapist is in control and responsible for the ongoing management of their injury.

The physiotherapist should assist the individual to use active strategies to manage their symptoms and to maintain function despite their symptoms. The worker needs to be given the confidence to be the key person in their own management. Active rehabilitation, which integrates clinic-based physiotherapy management in conjunction with restoration of activities of daily living, functional goal-setting and activity-pacing, will assist the worker to effectively manage their symptoms.

Principle four

Goals of physiotherapy management should be functional and focused on return to work

Key messages

1. Physiotherapy goals should relate to function and return to work. Goals should be specific, measurable, achievable, relevant and timed (SMART):

SPECIFIC	names the particular variable of interest (distance able to walk, hours at work on modified duties, difficulty driving)
MEASURABLE	has a measurement unit (metres, hours, 0-10 scale)
ACHIEVABLE	likely to be achieved given the diagnosis and prognosis for the worker's injury, and environmental constraints
RELEVANT	relevant/important to worker, relevant to return to work/function
TIMED	states timeframe within which the goal is expected to be achieved.

2. SMART therapy goals should be negotiated with the worker.

3. Goals should be assessed regularly and a record kept of goal achievement.

4. New goals should be formulated as early goals are met or revised.

Physiotherapy management goals focusing on return to work and function need to be developed in collaboration with the worker and with knowledge of the worksite.

New management goals are set as the worker progresses, circumstances change or barriers to return to work are identified.

Should all goals be functional?

In some cases, goals based on impairments may be appropriate. For example, in an acute injury, pain reduction may be an appropriate treatment goal.

Examples of management goals

Poorly constructed management goals	Smart goals
To increase sitting endurance	To increase sitting endurance at the desk from 5 to 15 minutes within one week
To improve driving	To decrease difficulty driving from 8/10 to 5/10 within two weeks (i.e. patient specific functional scale)
To increase function	To return to modified work duties for three hours per day within three weeks

Principle five

Physiotherapy management should integrate the best available research evidence with clinical expertise and patient values

Key messages

1. Physiotherapists should use the best evidence available to form the basis of their management.
2. Systematic reviews, clinical practice guidelines and critically appraised papers/topics provide the most comprehensive research-based information.

Sourcing the best evidence

The most accessible source of research evidence is 'pre-appraised' evidence such as systematic reviews, clinical practice guidelines and critically appraised papers and topics.

Examples of 'pre-appraised' evidence include:

1. The Physiotherapy Evidence Database (PEDro) <http://www.pedro.fhs.usyd.edu.au/index.html> is a database of clinical trials and systematic reviews related to physiotherapy.
2. Clinical Practice Rehabilitation Guidelines http://www.health.uottawa.ca/rehabguidelines/en/search_results.php.

Examples of evidence-based practice guidelines include:

1. The Cochrane Library
<http://acc.cochrane.org/cochrane-library>. This is a free site that includes systematic reviews of research evidence.
2. National Health and Medical Research Council <http://www.nhmrc.gov.au/publications/synopses/cp94syn.htm>. This website includes information on research and publications.
3. National Guideline Clearinghouse
<http://www.guideline.gov/>. This website includes information on guidelines and relevant journals.
4. The Australian Physiotherapy Association 'Evidence based guidelines'.
5. The Australian Journal of Physiotherapy regularly presents critically appraised papers that evaluate high quality research reports.

Principle six

Communication between professionals involved in a worker's rehabilitation will optimise outcome

Key messages

1. Physiotherapists will respect the privacy of their patient, in particular all sensitive and personal information provided to them. An *Authority to release information* must be obtained from the patient prior to any form of communication with another person.
2. Physiotherapists may be required to communicate with and receive communications from various stakeholders within the rehabilitation team.
3. Communication should occur at various stages in the course of rehabilitation, at least periodically or following significant events.
4. Physiotherapists will report non-compliance with treatment recommendations when such a pattern occurs.

Who to communicate with

Stakeholders involved in a worker's rehabilitation may include the certifying medical practitioner and other allied health practitioners, the employer, case manager, legal representatives and the worker. Physiotherapists should provide the case manager with a management plan or progress report when requested to do so.

When to communicate

Communication with stakeholders should occur periodically or at significant stages during the course of rehabilitation. This could be:

- following initial clinical assessment
- prior to medical review
- prior to the expiration of a *WorkCover Medical Certificate* (WMC)
- prior to specialist or independent consultant assessment or review
- every six to eight weeks to document progression
- following significant change of health status or functional capacity.

How to communicate

There are a number of ways to communicate with stakeholders involved in a worker's rehabilitation. Communication methods may include:

- phone calls
- reports
- management plans
- case conferences.

Principle seven

Physiotherapy management should cease once attainment of optimal outcome has been achieved

Key messages

- 1. Physiotherapy management should progress toward self-management which reduces dependence on professional support.**
- 2. Physiotherapy management that fails to make measured progress toward functional goals, activity-related or participation-related goals should be ceased.**
- 3. The psychosocial effects of withdrawing physiotherapy management should be determined and managed.**
- 4. The decision to withdraw physiotherapy management should be conferred and agreed upon by all members of the rehabilitation team.**

Strategies in cases where benefit from physiotherapy management is no longer demonstrated could include the following:

- reference to the Clinical justification flowchart on the WorkCover website
- analysis of prognostic indicators, contributing factors, red and yellow flags, and obstacles to recovery
- re-evaluation of goals and re-selection of outcome measures
- instituting a 'measured trial of no treatment'
- seeking informal opinion from a professional peer or mentor
- independent clinical assessment
- requesting a case conference.

Continued attendance at non-progressive treatment should not be used as a de facto indicator or justification of ongoing impairment. A physiotherapist's opinion on ongoing impairment should be communicated to the certifying medical practitioner and rehabilitation team. Where a final determination on permanent impairment is pending, the worker may be supported with periodic physiotherapist review of self-management, prescribed exercise or prescribed activity therapy.

Where detrimental psychosocial consequences associated with the removal of physiotherapy have been determined, measurement of wellbeing, depression and engagement may be instituted. In these situations, referral to and collaboration with other members of the rehabilitation team should be considered.

Appendix 1

This is an example of treatment goals and outcome measures that you can use.

Patient:					
	Date	Date	Date	Date	Date
Standardised outcome measure					
1.					

Patient-specific functional scale					
1.					

PSFS average score					
Pain intensity (0-10 visual analogue scale)					
Customised outcome measure					
1.					

Physical (impairment) measures					
1.					

Psycho-social outcome measure					
1.					

Goals and timeframe					
1.					

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The following free information support services are available:

If you are deaf or have a hearing or speech impairment you can call WorkCoverSA through the National Relay Service (NRS):

- TTY users can phone 13 36 77 then ask for 13 18 55.
- Speak & Listen (speech-to-speech) users can phone 1300 555 727 then ask for 13 18 55.
- Internet relay users can connect to NRS on www.relayservice.com.au then ask for 13 18 55.

For languages other than English call the Interpreting and Translating Centre (08) 8226 1990 and ask for an interpreter to call WorkCoverSA on 13 18 55. For Braille, audio or e-text call 13 18 55.

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