

Vocational rehabilitation framework – Model options Final report

*Prepared for
WorkCoverSA*

Model options report

March 2011

pwc

*What would
you like to grow?*

Contents

Executive summary	3
1 Introduction	7
1.1 Background	7
1.1.1 Rationale for the review	7
1.1.2 Overview of project scope	8
1.2 Methodology	8
1.2.1 High level approach	8
1.2.2 Key activities	9
1.3 Roadmap to the report	10
2 The current South Australian experience	12
2.1 South Australia at a glance	12
2.2 Vocational rehabilitation use and cost	12
2.2.1 Data requested	12
2.2.2 Basis for comparison	13
2.2.3 Results	13
3 Overview of the current vocational rehabilitation model	19
3.1 Key themes from consultations	19
3.1.1 Underpinning factors	19
3.1.2 Vocational rehabilitation and return to work principles and elements	24
3.2 Comparison to best practice and other jurisdictional models	29
3.2.1 Vocational rehabilitation provider monitoring, management and remuneration	30
3.2.2 Regulatory oversight	31
3.2.3 Capability building	32
3.2.4 Segmentation and triage	32
3.2.5 Strategic rehabilitation process	33
3.2.6 Other key elements for consideration	34
4 Model options	35
4.1 Overview of proposed model options	35
4.1.1 Underpinning framework	35
4.1.2 Proposed model options	37
4.2 High level costing of options	39

4.2.1	Vocational rehabilitation remuneration	39
4.2.2	Structural model options for vocational rehabilitation	40
4.3	Implementation considerations and concluding remarks	40
	Appendices	41
Appendix A	Glossary	42
Appendix B	Interview schedules	43
Appendix C	Invitation letter	47
Appendix D	Statistics on SA	48
Appendix E	Data requests	49
Appendix F	Jurisdiction summaries	53
Appendix G	References	66

Executive summary

Background

The South Australian Workers Rehabilitation and Compensation Scheme (the Scheme) is regulated and overseen by the WorkCover Corporation of South Australia (WorkCoverSA). The Scheme aims to rehabilitate and compensate workers who have been injured following a workplace incident, with the ultimate goal of keeping injured workers at or safely returning them to work and the community. As part of this process, the management of workers compensation claims is outsourced to a single scheme agent.

Driving forces

Over the past five years, WorkCoverSA has experienced increasing utilisation and cost of vocational rehabilitation services, but with little observable improvement in return to work outcomes. More importantly, this situation has emerged regardless of the recent structural and environmental changes that have occurred within South Australia (SA), which raises a number of questions.

There are three key factors contributing to SA's current situation:

- **Benefit structure** – the SA Scheme has a history of a relatively generous framework of benefit entitlements, including weekly benefits and redemptions. It is argued that the level of weekly benefit entitlement continues to present an obstacle to successful rehabilitation (little financial incentive to return to work) in the absence of skilled support for injured workers. The 2007 scheme review did not recommend major reductions in short term weekly benefit entitlements for injured workers. However, it did find that without successful return to work outcomes; through active support of injured workers, injury management and rehabilitation, the scheme would struggle to deliver the required long term financial outcomes.
- **Compensation culture** – recent changes in legislation (particular the removal of most redemptions) responded to a view that redemptions can be contrary to the Scheme's objective of supporting injured workers to stay at or return to work. The first phase of legislative change came into play in mid 2009; however, it was only since July 2010 that all claims became subject to the new legislation. In the meantime there has been (and continues to be) a compensation culture within the scheme, rather than one which promotes a co-operative outcome for both injured workers and employers. Skilled intervention will be required to influence a change in this culture.
- **Claim management and vocational rehabilitation effectiveness** – to date the existing model of claim management and vocational rehabilitation has not demonstrated the ability to provide this skilled intervention, particularly through targeted early referral to rehabilitation in appropriate cases. The main purpose of this report is to focus on options for re-engineering these processes and building the capacity and capability required to resolve the mismatch between increasing vocational rehabilitation spend and stagnating return to work outcomes.

These three factors – ie the current compensation culture, benefits structure and weak case management and vocational rehabilitation practice appears to be exacerbating the consequences of late referral to necessary interventions.

Aims of the review

In light of this experience, WorkCoverSA engaged PricewaterhouseCoopers (PwC) to undertake a review of the current vocational rehabilitation service framework and fee model in SA to:

- assess vocational rehabilitation utilisation and cost in SA, in the context of similar schemes

The success of a vocational rehabilitation framework is critical to achieving durable return to work outcomes for injured workers.

- identify key issues and barriers contributing to incongruous return to work outcomes, compared to vocational rehabilitation use and spend
- obtain and reflect on learnings from best practice and other jurisdictions, which may serve as enablers to realising improvements in return to work outcomes for injured workers
- identify ways to strengthen the SA vocational rehabilitation remuneration structure
- develop and propose a range of best-fit model options for vocational rehabilitation service delivery and remuneration, informed by the review findings.

Key findings from the review

In this report we have found that to date the scheme shows little evidence of improved return to work performance, in spite of very heavy referrals to and cost of vocational rehabilitation compared to comparable schemes. We have heard that the case management structure has not been successful in identifying those injured workers most likely to benefit from vocational rehabilitation. Moreover, there is a lack of active engagement between the case manager and the vocational rehabilitation sector to provide injured workers and employers with constructive return to work support. Return to work outcomes remain poor, while the cost of vocational rehabilitation is high – vocational rehabilitation for the first two years post-injury represents an investment of around \$12m per injury year. Moreover, the nature of the rehabilitation services seems more frequent and prolonged than in other jurisdictions.

Fee structures do not encourage short term and targeted vocational rehabilitation

The current vocational rehabilitation remuneration model does not adequately promote or reward timely and durable return to work. In fact, the use of hourly rate billing practice and fixed fee for service may encourage rehabilitation to be prolonged and solutions to be ‘off the shelf’, rather than tailored to an injured worker’s circumstance.

There is a need for a more performance-based vocational rehabilitation remuneration structure, as an avenue for incentivising timely return to work. Furthermore, performance management of both the claims agent and providers needs a stronger focus on actual return to work rates and outcomes.

The vocational rehabilitation market needs to be defined by quality and skill

When compared to other jurisdictions, there is an overservicing of claims through the use of vocational rehabilitation services, without corresponding outcomes. Furthermore, the high number of vocational rehabilitation provider companies within the SA workers compensation market may not be conducive to achieving good return to work outcomes nor optimising the oversight capacity of the Vocational Rehabilitation Unit (VRU). A more outcome-focused incentive structure would allow the market to appropriately reward the more experienced and high performing vocational rehabilitation consultants, while rendering the market untenable for under-performing providers.

A strong regulatory influence is required

The paper also explores the current capacity of the VRU and how it compares to other schemes. Although the VRU is apparently resourced adequately with respect to scheme size (ie VRU has 4 FTE, Victoria has 7 FTE and NSW has 4 FTE), the key challenges faced within SA, as well as the generous entitlement structure would indicate a need to increase the VRU capacity in the short term.

Limited upfront strategic case management and early referral

Stakeholder consultations revealed that one of the major barriers to durable return to work is limited upfront and strategic case management practice. Whilst there is a general conceptual understanding of best practice principles by agent case managers, such as early intervention, communication and consideration of psychosocial risks, there is little evidence of such outcomes-focused behaviour translating to engagement with vocational rehabilitation providers and injured workers. Attempts to act early on a claim, through referrals to vocational rehabilitation providers, can sometimes lack clear direction, purpose and ongoing management, which appears to be contributing to the increasing utilisation and cost of vocational rehabilitation. In addition, other key themes from consultations included:

- limited active and ongoing monitoring of claims and stakeholders involved in the process
- limited collaboration between the case manager and vocational rehabilitation provider, and in particular early referral to rehabilitation in appropriate cases
- lack of communication and delays in decision making.

Other schemes have recognised the importance of managing high risk and complex files through capable staff with manageable case loads proactively managing files, undertaking face-to-face contact with key stakeholders, and referring to vocational rehabilitation providers using a targeted and purposeful approach.

Capability enhancement is required by the claims agent

Underpinning the limited upfront and ongoing management of claims is the reported lack of experience amongst agent case managers to be making fast and informed decisions, as well as the limited training and development opportunities for building internal capability.

Other jurisdictions are taking note of this challenge, with training and development programs being introduced in Queensland, New Zealand and Victoria in order to build expertise within the case management environment.

While the SA claims agent has advised this review of similar investment, there was little evidence or acknowledgement of such development among stakeholders consulted.

A recommended way forward

Vocational rehabilitation remuneration

A revised structure for remuneration of vocational rehabilitation is proposed within this paper, with a shorter term and more focused requirement, and incentives for return to work outcomes. This structure could be funded by savings from current return to work monitoring expenditure.

Referral and management structure

Four model options are proposed for a restructuring of the vocational rehabilitation approach, within a strong underpinning framework, and enhanced and focused capacity within the Corporation. All options must be supported by early intervention principles, clear and regular communication practices and a strong capability building approach, to facilitate the provision of the right service, right time and right cost principle. The model options are as follows:

- M1 Strong claims agent presence
- M2 Mixed claims agent and Regulator management approach

M3 Mixed claims agent and vocational rehabilitation provider management approach

M4 Current model with a redistribution of resources.

It is recommended that a number of pilot projects are considered with a view to testing components of the models.

1 Introduction

There is a disparity between spending on vocational rehabilitation services and achievement of good return to work outcomes. The review seeks to identify the key issues with the current service delivery and remuneration approach and propose better ways of working.

1.1 Background

1.1.1 Rationale for the review

The Workers Rehabilitation and Compensation Scheme in South Australia (the Scheme) is designed to support workers and employers, through appropriate rehabilitation and compensation, in helping keep injured workers at work or returning them to a safe work and the community. The Scheme caters to approximately 53,000 employers and 430,000 employees. The WorkCover Corporation of South Australia (WorkCoverSA) is responsible for regulating the Scheme and overseeing its outsourced operations.

In fulfilling the Scheme's primary objective of helping injured workers stay at work or returning them to safe workplaces and the community, effective injury management, employer involvement and vocational rehabilitation has been relied on to assist in meeting these objectives. Moreover, the primary injury is sometimes accompanied by barriers (eg industrial disputes, psychosocial issues), which must be recognised and managed to support the worker in returning to the workplace. A key strategy for addressing these types of issues and barriers is also through the delivery of vocational rehabilitation interventions and services by specialist providers.

"Workplace rehabilitation is a managed process involving timely intervention with appropriate and adequate services based on assessed need ... aimed at maintaining injured or ill employees in, or returning them to, suitable employment"[1]

The success of a vocational rehabilitation service framework is critical to achieving durable return to work outcomes for injured workers. In recent times; however, vocational rehabilitation expenditure in South Australia (SA) has increased, whilst commensurate improvements in return to work have not been observed. This apparent stagnation in good return to work outcomes, coupled with increasing vocational rehabilitation costs has led WorkCoverSA to consider and assess the current SA approach to vocational rehabilitation service delivery and remuneration.

WorkCoverSA has identified the following key contributors to this situation:

- High vocational rehabilitation service referral rates of claims on income maintenance payments, when compared to interstate jurisdictions
- Increasing servicing patterns for these income maintenance vocational rehabilitation service referrals
- Skill gaps within the vocational rehabilitation industry
- The work capacity assessment (WCA), which is driving large increases in total vocational rehabilitation expenditure.

This apparent stagnation in good return to work outcomes, coupled with increasing vocational rehabilitation costs has led WorkCoverSA to consider and assess the current SA approach to vocational rehabilitation service delivery and remuneration.

1.1.2 Overview of project scope

In response to this situation, WorkCoverSA commissioned PricewaterhouseCoopers (PwC) to undertake a review of the current vocational rehabilitation service framework and fee model in SA to:

- assess vocational rehabilitation utilisation and cost in SA, in the context of similar schemes
- identify key issues and barriers contributing to incongruous return to work outcomes, compared to vocational rehabilitation use and spend
- obtain and reflect on learning's from best practice and other jurisdictions, which may serve as enablers to realising improvements in return to work outcomes for injured workers
- identify ways to strengthen the SA vocational rehabilitation remuneration structure
- develop and propose a range of best-fit model options for vocational rehabilitation service delivery and remuneration, informed by the review findings.

Terms of reference

The vocational rehabilitation framework and fee model options should be capable of meeting the following high level objectives:

- Tighter assurance that all necessary activities, including retraining and job matching, support the delivery of return to work within appropriate timeframes
- Maximising workplace based rehabilitation services
- A demarcation in relation to workers requiring vocational rehabilitation services and those that do not, and a framework consistent with the national principle of right services, right time and right cost
- A payment framework that actually rewards key milestone attainment and return to work outcomes, and promotes innovation in the vocational rehabilitation industry
- A suitable ongoing approach for the review of base fee levels and general indexation
- An improvement to the rate, speed and sustainability of injured workers returning to work and to enhance their return to work experience.

1.2 Methodology

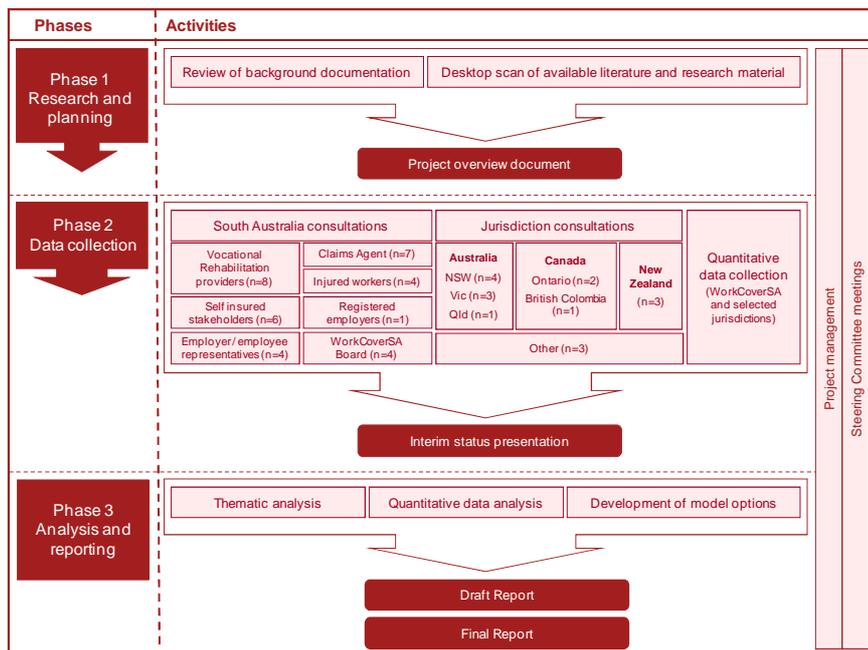
1.2.1 High level approach

The review was conducted over a three month period between August and November 2010 and involved three key phases of work:

- 1 Research and planning – review of background documentation and a desktop scan of available literature and research material
- 2 Data collection – core quantitative and qualitative data collection activities
- 3 Analysis and reporting – synthesis of information through quantitative data and thematic analysis, and development of model options.

Figure 1 below illustrates the high level approach of this review.

Figure 1 Vocational rehabilitation model review project methodology



1.2.2 Key activities

As depicted in Figure 1 above, the review was informed by a range of qualitative and quantitative sources of data: available literature and research material; stakeholder consultations; and quantitative data provided by WorkCoverSA and selected jurisdictions. This is outlined in more detail below.

Qualitative data collection

Desktop scan of literature

In undertaking a desktop literature scan it was found that extensive literature reviews into best practice principles of injury management and return to work have been published in the past, and are reasonably well agreed [2-5]. These principles of best practice injury management and return to work have been used throughout this report to provide guidance and underpin the rationale for the development of the model options for vocational rehabilitation in SA.

The SA government has commissioned a number of reviews into the workers’ compensation system [6-9]. These reviews were written during a time when SA had the lowest return to work rates of all Australian States and Territories, the highest levy rates paid by employers, and a continuing increase in the number of longer term injured workers and claims. These reports have been reviewed and incorporated, where applicable, within the context of this review and into the recommendations for model options.

Stakeholder consultation

A two pronged approach was adopted for the stakeholder consultations, which involved engaging representatives within SA and other national and international jurisdictions. A total of 51 stakeholders were consulted, the majority of which were undertaken as telephone interviews. Consultations primarily took the form of one-on-one interviews; however, a handful of consultations were undertaken as group-based interviews (ie more than one interviewee). These

interviews were guided by a number of key questions, which are outlined in Appendix B. In addition, four (4) stakeholders provided written responses, which contributed to the qualitative information gathered. Table 1 below provides a breakdown of the number of consultations undertaken and stakeholders interviewed by stakeholder group.

Table 1 Number of consultations by stakeholder group

Stakeholder group	Consultations (n)	Interviewees (n)
Employer/employee groups	3	4
Injured workers	4	4
Registered stakeholders ^(a)	6	8
Self insured stakeholders ^(b)	5	6
Vocational rehabilitation providers	7	8
WorkCoverSA Board	4	4
Jurisdictions ^(c)	8	14
Other	2	3

Notes: ^(a) Includes Employers Mutual (EML) representatives and a registered employer.

^(b) Includes self insured case managers and employers.

^(c) The following jurisdictions were consulted as part of this review: NSW, Vic and Qld (Australia); Ontario and British Columbia (Canada); and New Zealand.

Refer to Appendix C for a copy of the invitation letter sent out to stakeholders.

Quantitative data collection

A key question in evaluating the current system is whether or not utilisation and cost of vocational rehabilitation in SA is indeed high in the context of similar schemes.

New South Wales (NSW) and Victoria were identified as the most comparable Australian schemes, being monopoly government underwritten schemes, with outsourced claims management (although for SA this is to a monopoly provider). The schemes also have similar benefit structures, although the entitlement to weekly benefits in SA is somewhat more generous than in the other jurisdictions, even after the recent legislative changes. This is likely to have some impact on the capacity of rehabilitation to achieve successful return to work, although this differential is now far less than previously (especially compared to Victoria).

In order to conduct a high-level quantitative comparison of the three schemes, data were requested for the 2008/09 injury year, with experience in each development quarter (DQ – quarter following injury quarter) up to 30 June 2010. Data on the utilisation and cost of vocational rehabilitation services in SA were collected and analysed.

1.3 Roadmap to the report

The report follows the format outlined below:

1. Introduction: this chapter outlined the rationale for the review, the overview of the project and the methodology of the review
2. The current SA experience – data analysis: This section presents a comparison of vocational rehabilitation cost and utilisation across three schemes: NSW, Victoria and SA
3. Overview of the current vocational rehabilitation model: qualitative findings of the review and key learnings from other jurisdictions are presented

4. Model Options: recommendations and proposed model options for consideration are described. Four model options are proposed and are underpinned by a high level framework based on key learnings from jurisdictions and best practice
5. Appendices: additional supporting information, including a list of stakeholders consulted and jurisdiction summaries
6. Spreadsheet appendices: containing more detailed data analysis than appears in the report.

2 The current South Australian experience

This section presents the quantitative data analysis of the current status in SA. Vocational rehabilitation spend in SA is assessed in light of other similar schemes.

2.1 South Australia at a glance

The estimated resident population of SA is 1.64 million, with an increasing proportion of older residents (aged 65 years and over) (15.4%), comparably higher than other Australian states.

In terms of geographical distribution, SA's population is predominantly metropolitan, with 73% of the population residing in urban areas. Twenty-four per cent of the population are regionally based, with only 3% based in remote areas.

As in comparable jurisdictions, employer business distribution by size in SA is predominantly small (less than 20 employees) business (89%). Medium (20 – 199 employees) and large (greater than 200 employees) businesses represent 10% and 1% of employers, respectively. However the largest 1% of employers comprise nearly 50% of the total cost of claims – also similar to other jurisdictions.

Blue collar industries make up 43% of all employers in SA, followed by service industries (27%) and professional services (20%). However in terms of the number of employees working in these industries the majority are in blue collar industries (33%), followed by government¹ and community services (28%).

Refer to Appendix D for key SA statistics.

2.2 Vocational rehabilitation use and cost

2.2.1 Data requested

In order to conduct a high-level quantitative comparison of the three schemes, data were requested for the 2008/09 injury year, with experience in each development quarter (DQ - quarter following injury quarter) up to 30 June 2010. Specific data were requested on:

- For the three schemes², separately by small, medium and large employer:
 - Number of claimants receiving weekly benefits in each DQ, separately by total incapacity and partial incapacity
 - Number of weekly benefit claimants receiving vocational rehabilitation benefits in each DQ, separately by total incapacity and partial incapacity

¹ We note that most government employers are exempt from WorkCover levy in SA, and take direct liability for claims cost.

² The NSW data provided relates to the 2008 Policy Renewal Year. Hence the number of claims and costs do not represent a full injury year, and comparison across injury quarters may be distorted. However development within an injury quarter is legitimate, and allows us to accurately analyse rehabilitation patterns across claim development.

- Cost of weekly benefits in each DQ, separately by total incapacity and partial incapacity
- Cost of vocational rehabilitation benefits for weekly benefit claimants in each DQ, separately by total incapacity and partial incapacity
- Cost of other benefits for weekly benefit claimants in each DQ, separately by total incapacity and partial incapacity
- Number of employers and aggregate industry premium
- Additionally for SA, separately by small, medium and large employer:
 - Tabulation of vocational rehabilitation payments in each DQ by vocational rehabilitation code, including cost of payments, number of claimants, number of “visits” and number of “transactions”
 - Tabulation of vocational rehabilitation payments in each DQ by frequency (ie intensity) of visits, including cost of payments, number of claimants, number of “visits” and number of “transactions”.

These data requests are attached at Appendix E.

2.2.2 Basis for comparison

A direct comparison of data on rehabilitation utilisation for the three schemes would be difficult when one acknowledges the differences between the schemes in terms of:

- Size (in terms of covered population and employers)
- Inclusion of government employers and self-insurers
- Scheme benefit structure and overall cost of claims (over recent years the “breakeven” premium rate in Victoria has been about 1.3% to 1.5% of wages, in NSW 1.6% to 1.8% and in SA 2.5% to 3%).

Therefore, to build as meaningful as possible a comparison of rehabilitation utilisation and cost, the data below are presented as proportions of Total Incapacity (TI) benefits in each development quarter. While full analysis for SA is provided in the Spreadsheet Appendices, the remainder of this section focuses on these claims – they make up the bulk of the cost at these early durations post injury, and they are the “cleanest” in discussing the utilisation of vocational rehabilitation.

2.2.3 Results

Total incapacity weekly claims

It is not appropriate in a report like this, where interpretation of a data request between schemes may differ, to give detailed information on “headline” scheme parameters. However, based on the data we have received, it is unambiguous that the average TI benefit in SA is substantially higher than in the other jurisdictions.

In the absence of effective return to work intervention through case management working actively and early with vocational rehabilitation, this lack of financial incentive to return to work is bound to contribute to the difficulties being experienced in the scheme.

This interdependence between a continuing generous weekly benefit level and an intensive effort at and support for return to work was a key theme of the 2007/08 scheme review.

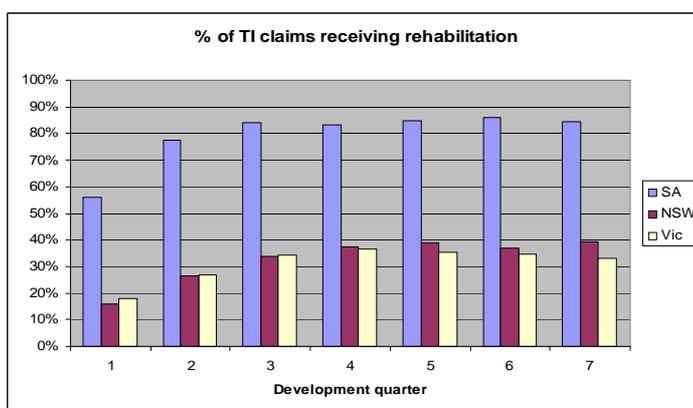
The latest scheme actuarial report³ does not provide any evidence of improvements of short-term return to work, so the increasing vocational rehabilitation costs discussed below do not seem to have achieved demonstrable outcomes at this stage.

We note also that since the premium *rate* in SA is considerably higher than in the other two jurisdictions, this method of comparison will *favour* SA – that is, any unfavourable comparisons determined below are actually even worse than indicated here.

Referral rate to vocational rehabilitation

Figure 2 clearly shows that the rate of referral to vocational rehabilitation is far higher (more than twice) in SA compared to NSW and Victoria, which are fairly similar.

Figure 2 % of TI claims receiving VR



Some of the patterns in this graph also warrant some further discussion:

- Ramp up: it is not until DQ 3 (ie on average around nine months post injury) that there is a plateau in the % of TI claims receiving rehabilitation. Hence while referral begins in DQ 1 (ie on average around three months post injury), this comprises only about 60% of claims eventually referred. We note also that this ramp-up is more pronounced in SA than in other states. Stakeholders to this review have reported that this delay in referral, in the absence of effective case management, is particularly damaging to return to work outcomes.
- Highlighting the Victoria patterns, the reduction in percentage of TI claims receiving vocational rehabilitation after the twelve month mark post injury reflects the short-term, focused nature of vocational rehabilitation in that state.

Average quarterly cost of vocational rehabilitation

Figure 3 shows the increasing average quarterly cost of vocational rehabilitation in SA compared to the other states – and the higher level of cost compared to Victoria⁴.

³ Finity Consulting. Scheme Actuarial Valuation as at 30 June 2010.

⁴ We note that the Victoria data highlights a component of rehabilitation spend on non-weekly claimant rehabilitation expenditure. This may explain part of the lower cost of VR, or alternatively may be explained by data inconsistencies.

Figure 3 Quarterly vocational rehabilitation cost per claim

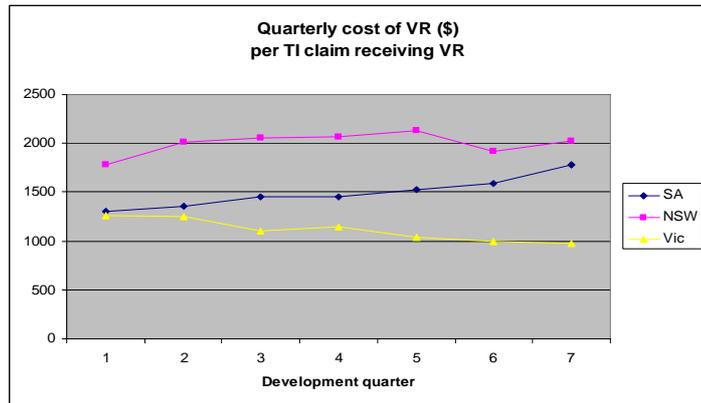
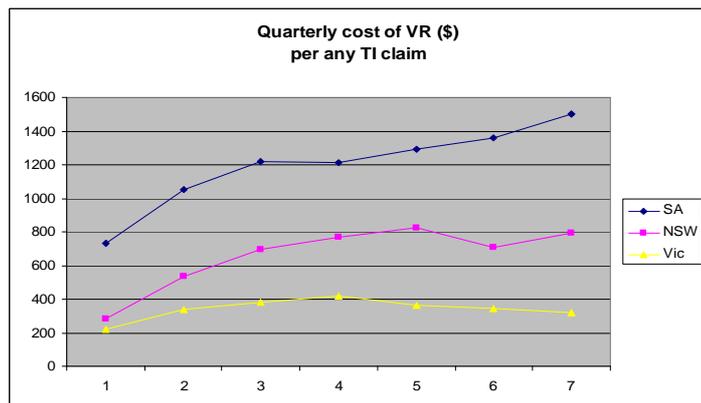


Figure 4 combines the average quarterly cost of vocational rehabilitation with the higher rate of vocational rehabilitation referral in SA. The result is a very high level of investment per weekly claim in SA, and a worrying upward trend compared to both other states, which highlights the persisting nature of vocational rehabilitation in SA – this is discussed later in this report.

Figure 4 Quarterly cost of vocational rehabilitation per all TI claims



The components of vocational rehabilitation in South Australia

To try to explain the above trends, more detailed information was requested on the specific frequency and cost of vocational rehabilitation utilisation in SA – this information was not requested from other jurisdictions, due to the unlikelihood of achieving comparative definitions.

Vocational rehabilitation codes and fee schedule

Figure 5 presents SA's vocational rehabilitation codes, and the fee rate and basis of payment (note: these rates have changed due to indexation and a revised agreement).

Figure 5 SA Vocational rehabilitation codes and fees

VR Code description	Code	Fee (\$)	
Initial rehabilitation assessment - pre-inj employer	RH101	629.5	fixed
Return to work preparation - pre-inj employer	RH102	129.5	per hour
Return to work monitoring - pre-inj employer	RH103	129.5	per hour
Initial rehabilitation assessment - new employer	RH201	629.5	fixed
Return to work preparation - new employer	RH202	129.5	per hour
Return to work monitoring - new employer	RH203	129.5	per hour
Job search activities	RH206	129.5	per hour
Progress report	RH402	129.5	per hour
Closure report	RH403	129.5	per hour
Travel	RH405	129.5	per hour
All other	All other		

Utilisation of vocational rehabilitation codes

Figure 6 presents the intensity of use and cost of these vocational rehabilitation codes for the September 2008 injury quarter, for two years up to 30 June 2010. It can be seen that \$2.8m was spent on vocational rehabilitation in the first two development years for this injury quarter – or \$11.2m per injury year. While the majority of this cost is on return to work preparation, this function still comprises less than 50% of the total investment. Initial assessment comprises about 10%, which seems appropriate, and return to work (RTW) monitoring comprises nearly 30% of the total – particularly for partial incapacity. Progress reporting and Travel time comprise a further 10% each.

Figure 6 Vocational rehabilitation codes

VR Code	N claims	N visits	All employers		Cost %	Visits per Initial assess
			Cost per visit (\$)	2-yr cost \$m		
Total Incapacity						
Initial rehabilitation assessment - pre-inj employer	321	326	549	0.18	8.0%	1.0
Return to work preparation - pre-inj employer	1034	11497	57	0.66	29.5%	35.8
Return to work monitoring - pre-inj employer	729	6059	52	0.31	14.0%	18.9
Initial rehabilitation assessment - new employer	108	110	587	0.06	2.9%	0.3
Return to work preparation - new employer	394	4928	64	0.31	14.1%	15.4
Return to work monitoring - new employer	111	510	53	0.03	1.2%	1.6
Job search activities	154	1219	79	0.10	4.3%	3.8
Progress report	1221	2608	71	0.19	8.3%	8.1
Closure report	323	334	69	0.02	1.0%	1.0
Travel	1121	2204	120	0.26	11.8%	6.9
All other		766		0.05		
Total TI	1580	30561	71	2.18	95.1%	95.2
Partial Incapacity						
Initial rehabilitation assessment - pre-inj employer	108	108	554	0.06	9.7%	1.0
Return to work preparation - pre-inj employer	189	1160	53	0.06	10.0%	10.7
Return to work monitoring - pre-inj employer	493	5605	50	0.28	45.6%	51.9
Initial rehabilitation assessment - new employer	5	5	599	0.00	0.5%	0.0
Return to work preparation - new employer	27	252	61	0.02	2.5%	2.3
Return to work monitoring - new employer	28	218	50	0.01	1.8%	2.0
Job search activities	13	54	102	0.01	0.9%	0.5
Progress report	460	959	72	0.07	11.1%	8.9
Closure report	149	149	63	0.01	1.5%	1.4
Travel	458	944	97	0.09	14.9%	8.7
All other		86		0.01		
Total	574	9540	64	0.61	98.4%	88.3

What has emerged from this analysis is the following “average pattern” for a TI claim in the September 2008 injury quarter, referred to vocational rehabilitation:

- Up to 80% of TI claims still receiving weekly benefits at three to six months post injury, receive an initial assessment, at an average cost of around \$550 (all costs are now higher)
- For the following 12 months (approximately) most of these claims receive a weekly “visit” from a vocational rehabilitation provider, coded as either return to work preparation or return to work monitoring in respect of the pre-injury employer – average cost per visit \$60 or about \$3,000 to \$4,000 in total
- About one-third of these (or other) claims receive a further initial assessment 15-18 months post injury, for a new employer - \$600

- There follows another round of weekly visits a further several months - average cost per visit \$60 or about \$800 to \$1,500 in total
- Most of these claimants will also undertake job search activities, typically around eight to ten times each at about \$80 per episode – total \$600 to \$800
- In addition, each injured worker receiving vocational rehabilitation will generate eight to ten reports on progress and eventually closure, at about \$70 per report – total \$600 to \$700
- Travel costs for the vocational rehabilitation provider adds a further 10% to 15% to the total cost

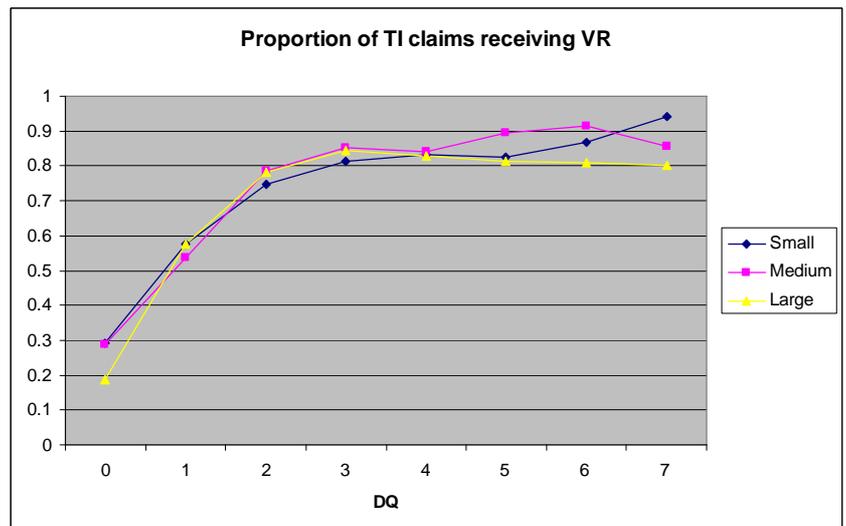
Typically, per claim referred to initial assessment, vocational rehabilitation costs amounted to about \$7,000 for the September 2008 injury quarter, for the first two years post injury.⁵

Analysis by employer size

As well as the scheme as a whole, data were requested for three bands of employer size, and this is presented for SA in the detailed Spreadsheet Appendices.

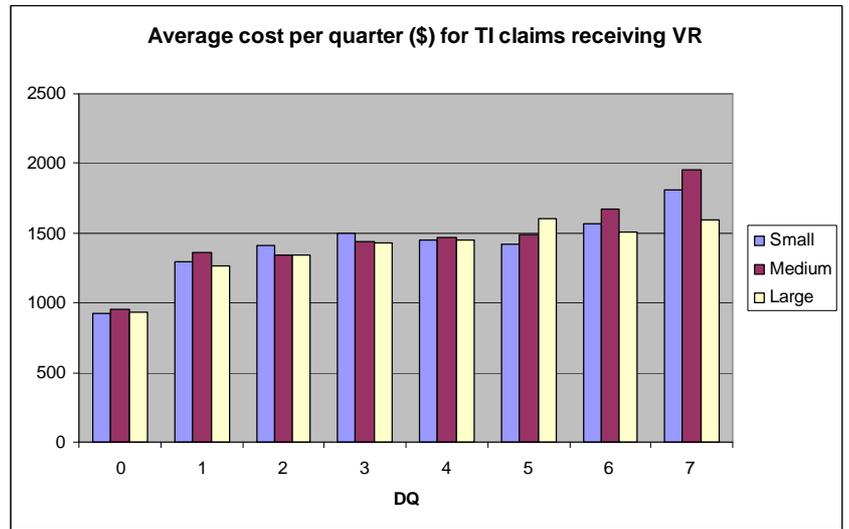
While some differences emerged between groups of employer size, the overall themes are similar, as shown in the following analyses.

Figure 7 Proportion of TI claims receiving vocational rehabilitation by employer size



⁵ It is acknowledged that vocational rehabilitation costs may also be expended on claims which do not receive an initial assessment

Figure 8 Average cost per quarter of vocational rehabilitation for TI claims receiving vocational rehabilitation by employer size



The theme that emerges is that while the trends are very similar, there is some weak evidence that for larger employers, the proportion of TI claims receiving vocational rehabilitation is a little lower at longer durations post injury, and for a lower average cost.

3 Overview of the current vocational rehabilitation model

Qualitative themes from stakeholder consultations are presented in this section. Key issues impacting on effective vocational rehabilitation and return to work are discussed. Learnings from other jurisdictions are also highlighted.

3.1 Key themes from consultations

A summary of key themes from stakeholder consultations is presented below, which primarily reflects the views and perceptions of stakeholders interviewed. These themes provide a snapshot of the current vocational rehabilitation model in SA. This report considers the themes in light of key vocational rehabilitation, return to work and case management principles and elements.

3.1.1 *Underpinning factors*

Vocational rehabilitation provider monitoring, management and remuneration

Remuneration of vocational rehabilitation providers

The current model for remunerating rehabilitation providers is predominantly a mixture of fixed fee for service and hourly rate billing, which does not incentivise durable return to work outcomes. In effect, the use of hourly rate billing practice and fixed fee for service may encourage rehabilitation to be prolonged and solutions to be ‘off the shelf’, rather than tailored to an injured workers circumstance.

In the case of the intensive job seeking program (IJSP), there is also a milestone payment component for sustained job placements at 13 and 26 weeks. An incentive bonus is also payable to the provider through the IJSP if a sustained outcome is achieved and the job placement occurred within the 20 week designated timeframe.

When asked about the feasibility of introducing a fee for outcome remuneration model to pre-injury return to work services, vocational rehabilitation providers had mixed views. The two key concerns raised through interviews in relation to a potential performance based pay structure were that it may encourage cream-skimming, and also may cause rehabilitation consultants to attempt a return to work before the injured worker is medically or otherwise able.

Provider monitoring and management

Vocational rehabilitation monitoring and management is the responsibility of WorkCoverSA and Employers Mutual (EML) and delineated as follows:

- WorkCoverSA is responsible for the licensing and approval of vocational rehabilitation provider companies, including the registration of their consultants. The Regulator is also accountable for auditing key provider activity (eg invoices, systems, security, staff competency and supervision etc), monitoring compliance with the contract and the Nationally Consistent Framework, as well as delivering some educational outreach with some of the providers.
- EML is responsible for the performance of vocational rehabilitation providers on claims, which includes interpreting provider results provided by

the Regulator and monitoring and managing the performance of providers through internal mechanisms, such as file audits.

The performance of vocational rehabilitation providers was reported through stakeholder consultations to lack monitoring or managing. After approval of proposed rehabilitation plans and any variation or increase in costs going forward, there appears to be little monitoring of rehabilitation activity and outcome against expenditure. Furthermore, while there are multiple methods of performance analysis available (review of self-reported data, EML file audits, WorkCoverSA audits, and the CAPO tool⁶) there seems to be little awareness of or use of these tools at the agent case manager and team leader level. It was reported that these may be used at higher management levels.

There was also consensus amongst stakeholders interviewed that the current self report model for vocational rehabilitation provider statistics is far from ideal. Vocational rehabilitation providers believe that the statistics currently reported on do not provide an accurate reflection of their performance and realisation of return to work outcomes (ie the complexity of files or an indication of quality of service of the vocational rehabilitation).

A further key issue identified, primarily by the vocational rehabilitation providers interviewed, pertained to a lack of decision making authority for the direction of the rehabilitation strategy, whilst still being accountable for the outcome. Most vocational rehabilitation providers indicated that they would welcome the opportunity to have greater control and decision making authority on cases.

Regulatory oversight

WorkCoverSA's role and responsibility as regulator in SA is to effectively oversee and regulate the operations of the workers compensation and rehabilitation system.

The Rehabilitation and Return to Work Inspectorate & Support Unit (Inspectorate) was established in SA as part of the 2008 legislative reform and in response to the recommendations in the 2007 system review. This Inspectorate mirrors the Victorian model and is focused on effecting early and durable return to work for injured and ill workers through the following key responsibilities: overseeing the accreditation and execution of return to work coordinators; enforcing the compliance of employer obligations under sections 58B and 58C; and providing advice and education to employers on return to work. The Inspectorate has a key role in facilitation of return to work when an employer is not cooperating.

The Vocational Rehabilitation Unit (VRU) has core responsibility for the provision of vocational rehabilitation related policy advice; the registration of vocational rehabilitation providers; and auditing and evaluating the performance of registered providers. Previous reviews have highlighted the important role that the VRU has and the specialist skills that it has across its team of approximately four people.

Other jurisdictions, such as Victoria and NSW, have similar units:

- Victoria's Return to Work Support Branch, within the Return to Work Division manages the vocational rehabilitation aspects of WorkSafe Victoria. This Branch has seven (7) full time equivalent (FTE) persons, consisting of a Branch Manager and six staff, with the following responsibilities:
 - 2 FTEs manage the day-to-day operations associated with the original employer and new employer service models

⁶ In any case, general feedback is that CAPO does not take into account key factors such as claim complexity.

- 2 FTEs manage compliance against contractual requirements, including the Nationally Consistent Approval Framework. These allocated resources are also responsible for leading new strategies and project initiatives
- 1 FTE manages the clinical panel/peer review process and has the shared responsibilities associated with the development of a triage tool
- 1 FTE provides support activities required in the Return to Work Support Branch, particularly in regard to contract governance requirements.
- The NSW Workplace Rehabilitation Unit has four (4) FTE; one Manager and three project staff. The Unit is responsible for vocational rehabilitation in NSW, which includes the development of tools and provider monitoring. However, it was noted that due to the volume of work, a stronger complement of resources would assist the Unit to work more effectively.

The resource allocation to the VRU does not seem inadequate when compared to the other jurisdictions and factoring in the size of the scheme. However, there also needs to be consideration to the performance of the respective schemes and the appreciation that NSW and Victoria do not have the same issues that SA currently faces. Furthermore, SA's generous entitlement structure is another factor that ought to be considered when comparing the three schemes.

The role of the VRU is crucial in any model going forward, particularly in enforcing a strict monitoring regime; as such, it needs to be resourced accordingly. This is particularly important given the extensive accreditation and evaluation methodology outlined in the Heads of Workers' Compensation Authorities (HWCA) Nationally Consistent Framework for Workplace Rehabilitation Providers[10]. The VRU will require additional resources to undertake this function, in addition to the other key advisory and regulatory roles. However, in light of the resource allocation across other schemes and their relative success, a short term increase in VRU capacity may be sufficient to address the current issues and build stability in the role.

This paper also acknowledges that a number of recommendations identified in the 2007 system review have been implemented through the 2008 legislative reform. These include, but are not limited to the:

- establishment of the Return to Work Fund
- introduction of the requirement for all employers with greater than 30 employees to have a return to work coordinator
- strengthening of the regulatory oversight role through the establishment of the Inspectorate.

Capability building

Vocational rehabilitation provider skills and knowledge

In terms of vocational rehabilitation providers, the HWCA Nationally Consistent Approval Framework for Workplace Rehabilitation Providers outlines the minimum qualifications, knowledge and experience required by vocational rehabilitation providers, as well as a high level learning and education framework that should be in place within the provider organisation. This framework provides a minimum set of requirements.

In Victoria, to ensure the rehabilitation consultants working within that jurisdiction are continually involved in professional development activities, WorkSafe Victoria is considering introducing a requirement for rehabilitation consultants to participate in 30 hours of professional development each year to continually increase and update their skills.

There also seems to be an opportunity to strengthen the training and job seeking competency of the vocational rehabilitation provider industry.

Consultations suggested that the skill sets and qualifications of rehabilitation providers may be insufficient for the purposes of retraining and job seeking. In addition, given the high number of accredited vocational rehabilitation providers and therefore competition to win work within SA, some vocational rehabilitation providers may be putting themselves forward as having those specialist skills, when in fact they are quite rudimentary. The training and recruitment sector appears to have more suitably qualified individuals to undertake these activities.

However, there is a definite opportunity for vocational rehabilitation provider companies to develop the skills of their consultants, in the broader sense, and therefore invest in the training and development of the vocational rehabilitation provider industry. This is important, as vocational rehabilitation providers should be seen as having independent and specialist skills, which can be drawn upon by a case manager when required on a claim.

Claims agent capability

The agent claims manager is responsible for the majority of decisions regarding a claim, including the initial identification of rehabilitation need and approval of vocational rehabilitation interventions going forward. There is a common view that many agent claims managers are inexperienced, lacking necessary qualifications and confidence to make soundly based decisions. This can lead to delays in key decision making and approval of appropriate services (eg transition services, work trials, work hardening), as highlighted by key stakeholders interviewed. Furthermore, this inexperience, coupled with potentially unused protocols, seems to be a key contributor to the increased referral to and extended use of vocational rehabilitation providers on lost time claims. In fact, one interviewee described the claims agent's case management and rehabilitation culture as "if in doubt, refer out". Rehabilitation provider stakeholders have also reported to this review that while referral rates may be high in SA, the delays in actually making the referral (in the absence of alternative effective case management) severely compromise return to work outcomes.

Compounding this situation is the high turnover experienced within the agent environment. For example, in a six month period, one claim can have multiple case managers. It is acknowledged; however, that the turnover rate has declined from approximately 30 per cent to 18 per cent.

Furthermore, a key contributor to this overall situation was the transition to a single agent model, which resulted in the majority of case managers, over a period of time, exiting the agent environment and new and inexperienced case managers being hired in their place.

There is an essential opportunity to improve the current capability building framework within the claims agent. This needs to take into account:

- a solid recruitment strategy, aimed at recruiting the right people with the right competencies to undertake the case management of high risk claims. While EML reported that they have a recruitment strategy in place, which targets workers with graduate qualifications and/or customer facing experience, this has not flowed through to industry perceptions
- the provision of targeted and mandatory internal training and development programs to upskill case managers, which is supported by coaching and mentoring. EML have reported that the new starter training program for the November intake will be including a component to address strategic use of rehabilitation
- offering case managers a clear career progression pathway, which includes professional development through external courses and conferences.

Communication, collaboration and role clarity

Regular communication between stakeholders involved in the workers compensation and rehabilitation process is critical in realising good return to work outcomes [4, 11].

By contrast, stakeholder consultations indicated that in SA, the communication between the agent case manager and the vocational rehabilitation provider is quite varied; ranging from a power struggle between the two parties to a complete handover of activity and direction to the provider. Furthermore, the vocational rehabilitation provider's independence and objectivity regarding advice and service delivery can be compromised by their need to maintain the relationship and win recurrent work.

There seems a need to improve collaboration and communication between the agent case manager and the vocational rehabilitation provider, particularly through clarifying roles, responsibilities and expectations. This could also be facilitated through an improved segmentation and triage model to achieve appropriate and early referral.

There also seems to be a lack of regular communication between the agent case manager and other key stakeholders (ie injured worker, employer). In particular, there appears to be an absence of face-to-face contact, which is a fundamental element in the rehabilitation and return to work process. This lack of capacity by the case manager to provide face-to-face contact is a key motivation for referring to a vocational rehabilitation provider. Consultations revealed that the vocational rehabilitation provider is often seen as the constant in the process and a general source of information for injured workers, employers and treating doctors. This theme; however, is not new to the SA context, with previous reviews identifying similar findings – ie the need for a human interface [6-8].

EML have commented on this finding, that currently face-to-face contact with the worker is generally driven from the Detached team (see below for a description of EML's teams). Increased face-to-face communication between the agent case manager and injured worker, within the Attached team, is expected to commence in 2011. For the purpose of this review, which is focused on early intervention and return to work as soon as possible, this current lack of face-to-face communication by the Attached team is a key finding.

Early intervention

It is well known that early intervention across the rehabilitation and return to work process is critical. Research is consistently finding that early intervention is one of the key tools in managing effective rehabilitation and realising outcomes. Early return to work strategies can dramatically eliminate unnecessary time loss associated with injury and disability [11-13]. Key timeliness and early intervention applications include:

- early risk assessment, since research suggests that individual and psychosocial factors are predictive of claim duration and/or outcomes [4, 14, 15]
- early medical intervention, shown to promote physical recovery [3, 16]
- early return to work or continued duties – despite the possible presence of pain, this has been shown to be associated with improved outcomes [17]
- early reporting of claims for effective case management and rehabilitation. Late reporting has a clearly demonstrable impact upon claims costs [18].

Although the majority of stakeholders acknowledged the importance of early intervention, there is still an opportunity to do this better, particularly when it comes to timely referral to appropriate vocational rehabilitation services.

3.1.2 Vocational rehabilitation and return to work principles and elements

Segmentation and triage

Segmentation

The purpose of claims segmentation is to stream specific injured worker groups with similar needs to case managers that possess the appropriate, and where necessary, specialist skills to manage the needs of those injured workers within finite resources. The aim of such streaming is to achieve optimal outcomes for both the injured worker (return to work and health) and the scheme (social and financial). A critical component of this streaming process is the decision of which claims require vocational rehabilitation, and which provider is most appropriate for a particular claimant.

There are three core teams within EML responsible for managing claims: Fast Track, Attached, and Detached. Each team is responsible for a particular part of the injured worker or claim journey. For example, the Fast Track team is primarily responsible for claims that have no lost time or where the time lost is not anticipated to be greater than 10 days. The overall philosophy of this team is fast and early intervention. The Attached team manages time lost claims and claims that are initially identified as complex (ie psychological claims, serious injury, hearing loss or where the claimant is a self-employed director) and stream claims based on employer and industry. Claims that cannot be returned to their pre-injury employer are managed by the Detached team, where claims are categorised as return to work or work capacity review focused (based on time since injury).

EMLs current segmentation model conceptually incorporates certain aspects of a best practice segmentation approach; for example, EML reported that: the Fast Track team is underpinned by an early intervention philosophy, there are criteria for immediate escalation/ streaming (eg psychological claims, self-employed director), psychological claims are reviewed by a Manager and the management strategy is development jointly between the Manager and the Case Manager.

Nevertheless, there are areas where EML may improve their segmentation and management approach. For instance, consultation outputs and data analysis identified that files may sometimes remain in the Fast Track team for up to two months. In addition, a greater number of factors could be considered to determine the complexity/risk of claims streamed to the Attached team, over and above the current escalation criteria (ie psychological claims, self-employed director), and matched to more experienced case managers.

Moreover, while EML have provided their conceptual segmentation model, based on consultations there is no awareness among stakeholders of such an organised and active process occurring in practice.

Initial risk assessment and triage

In order to support a well structured segmentation model, a rigorous process for identifying risks associated with a claim and injured worker is important. This risk screening or assessment process should be linked to the segmentation model and therefore guide the way in which a claim is triaged to the right team and finally allocated to the most appropriate case manager and, where necessary, rehabilitation provider.

Findings from consultations seem to indicate that agent case managers do not use any specific tools or resources to assist them in undertaking a claims risk assessment, other than vague guidelines regarding incapacity and injury type (eg psychological). Having said this, agent case managers generally do have an understanding of the various red and yellow flags (eg co-morbidity, passive

attitude of the injured worker to rehabilitation). Furthermore, agent case managers are generally relying on their own (sometimes quite limited) experience for initial risk assessment.

EML reported that In June 2010, a refined early contact checklist was introduced to assist case managers to assess the needs on a claim and identify any key risks to be managed. The tool covers the following key areas: injury work environment, social circumstances, and economic factors. To support the rollout of this tool, EML reported that case managers were also provided with training on facilitating early contact.

Through the stakeholder consultations, it was also reported that an insurer in another Australian jurisdiction had a dedicated team who work on specific high risk files. Case managers in this group had lower case loads (approximately 25 files) and access to an in-house injury management advisor (IMA) and doctor. Key activities included intense early contact through face-to-face case conferences (eg triggered at 4 weeks if no return to work), and meetings with employers. Case managers were responsible for driving the file, even when an external rehabilitation provider was involved. It was reported that there were good return to work rates and claims generally did not continue post 13 weeks.

Strategic rehabilitation process

An overarching theme from consultations is that current activity is primarily back end focused and aimed at undertaking WCAs to assess ongoing entitlement to income maintenance payments, rather than focused on early intervention and timely return to work. This observation is supported by EML's submission that face-to-face contact occurs primarily in the Detached team.

Due to this focus, protracted vocational rehabilitation for ongoing return to work preparation and monitoring appears to be the key contributor of high rehabilitation cost without the commensurate return to work outcomes.

A common perception is that claims are managed on a day-to-day basis without a tailored and outcomes-based focus. There was also a perception amongst stakeholders that agent case managers lack the capacity and/or capability to make strategic decisions on files. This is a key issue given the importance of timely and sound decision making on successful return to work.

Consultations with EML staff noted an average case manager case load of about 70 claims, which has reduced over time and is comparable to other insurers and jurisdictions. Other feedback from EML noted that case managers have had an average case load of below 60 for the past three years. Regardless, the degree of autonomous decision making across agent case managers is reported to be limited, with many decisions and approvals being escalated to the team leader. Although the team leader does not have a dedicated case load, they are responsible for a team of approximately five to seven case managers, which translates to an unofficial case load of roughly 350 claims.

As observed above, there is also substantial variation reported in the way vocational rehabilitation claims are managed depending on the culture of the group within the claims agent (ie Fast Track, Attached, and Detached) and the actual case manager. For example, it was highlighted through the consultations that the Detached environment appears to have more confident and competent case managers who drive the claims process and direct the vocational rehabilitation providers. On the other hand, the Attached team appears to lack this more proactive approach, refer out claims for case management functions and undertake little monitoring or management of vocational rehabilitation providers.

By contrast, within the self insured environment, the case manager is responsible for coordinating, managing and driving the file and return to work using a very 'hands on' approach. For example, the case manager works closely with the internal rehabilitation provider, relevant specialists and attends

worksite assessment and case conferences with the nominated treating doctor (NTD). This is a highly consultative approach, adopting a strong early intervention philosophy (eg early contact and timely decision making), that is ultimately focused on achieving good durable return to work outcomes.

Identification of need for vocational rehabilitation

Stakeholders interviewed acknowledged that there is inappropriate use of vocational rehabilitation at the moment. It was reported that there seems to be a tendency for agent case managers to refer to vocational rehabilitation providers without a clear understanding of the needs of the injured worker or specifically why they are referring, beyond the basic referral goal of “return to pre-injury employer”.

The vocational rehabilitation industry indicated through consultations that a key barrier to timely return to work and contributor to lengthy interventions and high expenditure is delayed referral for vocational rehabilitation. It was highlighted that in some instances, by the time the provider is involved, the situation had deteriorated; making it more difficult to realise good return to work outcomes. While over-vigorous and indiscriminate early referral to vocational rehabilitation incurs a risk of cost-escalation, delayed referral on appropriate claims can have a very negative impact on outcomes and cost. The skill of the “Attached” case manager and the quality of segmentation and triage are critical.

Within the self insured environment there is strong injury management adviser/rehabilitation specialist involvement early on in the process to identify the needs of the injured worker and claim. In most cases, where rehabilitation intervention is required, an internal rehabilitation consultant is involved. Referral to internal rehabilitation occurs early in the process. Key reasons for referral include: industrial issues, claiming history, and others.

In some circumstances, a referral to an external rehabilitation provider is made – this is usually due to time and capacity constraints or the geographical location of the injured worker. When this happens, the referral reason and goal is very clear and a collaborative approach is taken. For example, one self insured interviewed mentioned that if internal rehabilitation has not been effective at six weeks and the injured worker has not returned to suitable duties, the claim will then be referred to an external vocational rehabilitation provider.

Vocational rehabilitation provider engagement

A common theme from consultations pertained to vocational rehabilitation provider referrals and the basis for these referrals. Although it was acknowledged that referrals should be based on provider performance, consultations indicated that in reality selection of a provider and referral to that provider tends to be heavily influenced by the relationship between the case manager and the vocational rehabilitation provider.

While advantages relating to the relationship driven referral process were cited – eg the vocational rehabilitation provider understanding an employer’s business or having rapport with the agent case manager and other key stakeholders – a key drawback was that of constrained independence regarding the provision of expert advice, sound decision making and appropriate service delivery, on the part of the provider.

Consultations indicated that vocational rehabilitation providers were not only receiving referrals for targeted rehabilitation interventions, but also for traditional case management functions (eg explaining legislative requirements to stakeholders, handling industrial disputes, requesting medical reports from treating doctors). This was highlighted as a potential contributor to increased rehabilitation expenditure.

It was also noted through the consultations that there are currently too many providers within SA. For example, it was reported that engaging with a number

of providers made it difficult for case managers to communicate and maintain relationships.

Change of goal determination and transition services

Delays in decision making and approval for retraining were noted through stakeholder consultations. For example, when an injured worker is no longer able to return to their pre-injury employer, it was reported that in some instances it can take up to between six and 12 months for a decision to be made and retraining to be approved by the agent case manager. This delay in decision making and action means that the injured worker is separated from their workplace and left at home; with their situation often deteriorating, the injured worker becoming disengaged and secondary injuries (ie psychological) often emerging.

However, EML noted that retraining does require evidence of identified suitable employment and completion of a retraining submission by the vocational rehabilitation provider, which could be contributing to some of these experienced delays.

SA Unions is currently piloting a project 'Retraining Injured Workers for Employment', which is one of seven projects in the first round of the return to work fund. The key aim of the project is to improve return to work through the provision of retraining services and identify ways in which retraining can be embedded into the rehabilitation and return to work process. Currently there are 33 project participants, with seven injured workers participating in training. Through the project, the following key activities are undertaken: 1) a skills assessment is completed on the injured worker, which also considers values and preferred industries of employment; 2) research on training options, which may include a visit to one of the Industry Skills Boards for advice on potential pathways; and finally 3) the injured worker is provided with training options to select a preferred option which is then put forward to the rehabilitation provider. Preliminary findings indicate that this pilot is having positive outcomes. For example, the project includes the recognition of prior learning (RPL) process, which allows for skills and knowledge to be recognised (ie through an RPL assessment), regardless of how, when or where they were obtained. The pilot has also received positive feedback from a rehabilitation provider perspective – specifically, it was noted that the pilot assisted in getting training approved and addressing issues with a non-complying worker.

Delays in change of goal determination (ie from pre-injury employer to new employer) were also raised through the interviews. However, it was reported by EML that there have been changes to the New Employer Transition (NET) framework to improve timeliness of decisions and file documentation. The extent to which adjustments to the NET framework translate to reducing delay should be closely monitored.

Assessment of the likelihood of returning to the pre-injury employer or to detach the worker needs to be made earlier than is presently the case. Consultation outputs suggest that this determination should often be possible at the 10 to 12 week mark on a claim.

Finalisation of rehabilitation services

As mentioned above, a vocational rehabilitation provider often stays attached to a claim for the purposes of developing return to work plans, progress reports, and undertaking return to work monitoring. It was mentioned through consultations that this typically happens, even when the vocational rehabilitation consultant on the claim indicates that rehabilitation intervention should cease or the claim is deemed to be a 'compliance' claim that has the outcome objective of determining ongoing entitlement to weekly benefits (ie because the claim is approaching or has reached the 130 week point).

Other key elements for consideration

The employer and workplace

Identifying suitable duties within the pre-injury employer can sometimes be a challenge, particularly if the agent case manager and/or vocational rehabilitation provider is not familiar with the employer's business or where the employer is a small business. Self insureds often do this well because most of the stakeholders engaged in the process are familiar with the injured worker's situation and the workplace characteristics and intricacies. For example, one large self insurer uses their on-site branch managers to drive the rehabilitation and return to work process and has reported good results. The Site Manager is expected to write the return to work plans when medical certificates come in, and forward to the injury management advisor or internal rehabilitation consultant for verification. The internal case management and rehabilitation team has good relationships with the employer site managers and a good understanding of the employer's business.

There seems to be an opportunity for the employer to be further engaged in the return to work process, for example:

- return to work coordinators could be utilised more for return to work monitoring and other ongoing and non-specific return to work related activities. These are currently being undertaken by the vocational rehabilitation provider
- there is a need for greater involvement by the direct supervisor (similar to the self insured model example described above)
- there is a need for a different focus of the model for small and large employers, but still based on similar principles. Smaller employers will have substantially less internal capacity and therefore require more assistance from a vocational rehabilitation provider.

The nominated treating doctor

Workers compensation systems in Australia are still medically dominated, and NTDs are sometimes barriers to the rehabilitation and return to work process.

Through the consultation process, a number of examples were identified of where alternative NTD models are in use, primarily within the self insured environment. These are described below:

- Early medical assessment team – a group of medical practitioners located close to each employer site that provides injured workers a guaranteed medical visit on the same day (ie early medical contact). This group of medical practitioners are aware of the workplace and the site manager provides a list of suitable duties for the injured workers to take to the treating doctor on the first visit.
- Injury care program – network of doctors and physiotherapists that provide medical care within two to four hours. Injured workers are given four visits to the doctor/physiotherapist and receive \$100 worth of medications; this is all without lodging a claim. This program has turned employees views around about the stigma of lodging a claim and contributes to early reporting. Injured workers are able to choose whether they use the program or lodge a claim in the first instance.
- Some self insured employers also provide onsite NTDs and other providers (eg physiotherapist, nurse), which has the advantage of familiarity with the workplace and job requirements.

Such models will need to recognise the right of the injured worker to seek the NTD of their choosing and have appropriate protocols in place to prevent

occurrences of employers 'coercing' injured workers to see an employer preferred NTD or not to lodge a claim.

Although engaging with the NTD is a known barrier and difficult to address, as experienced in other jurisdictions, it has been said that due to SA's size and concentration, there is more personal knowledge of NTDs, and consultations actually revealed that both agent case managers and vocational rehabilitation providers are generally able to identify those NTDs that may pose a problem to or delay return to work.

There is also an opportunity to provide more job specific information to the NTD in a consistent manner. For example, having a job dictionary ready to send with the injured worker to the NTD for suggested suitable duties. This should be encouraged and facilitated through the return to work coordinator role and include a list of potential suitable duties.

The injured worker

The motivation and attitude of injured workers is also key to realising good return to work outcomes. Educating employees, employers and NTDs on the benefits of work should be a key strategy. This also links in with the current prevention and wellness agenda and key findings from the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) of the Royal Australasian College of Physicians (RACP), which emphasises the fact that good work has been shown to assist with recovery.

The AFOEM has developed a position statement titled '*Realising the Health Benefits of Work*' [19]. The position statement has two underpinning principles which have a strong international evidence base that require increased general population understanding:

- work, in general, is good for health and wellbeing
- long term work absence, work disability and unemployment have, in general, a negative impact on health and wellbeing.

Both internationally and within Australia, there is growing awareness that long-term work absence, work disability and unemployment are harmful to physical and mental health and wellbeing. The education of all stakeholders from government to employers and workers has been identified as an important strategy to assist the workers compensation industry.

3.2 Comparison to best practice and other jurisdictional models

The previous section described the current vocational rehabilitation framework within SA, including the key issues and themes identified through stakeholder consultations and quantitative data analysis. In addition, some high level learnings and potential opportunities were noted, where applicable.

This section of the paper highlights key learnings from the jurisdiction consultations and available best practice research. Table 2 below summarises the best practice elements and principles discussed in the paper, which also inform the proposed model options described in Section 4.

While it is difficult to attribute the contribution of key return to work outcomes to specific individual best practice principles, the available literature does highlight the importance of embedding these principles within an injury management, rehabilitation and return to work model, in order to optimise outcomes for both injured workers and schemes.

Table 2 Summary of best practice elements and principles

Broad area	Principle / element
Overarching	Strong regulatory oversight
	Early intervention
	Collaboration and communication
Performance management and remuneration	Performance management against outcomes
	Performance-based remuneration
	Vocational rehabilitation provider accountability
Segmentation and triage	A segmentation model aligned to specialisation
	Risk-based triage
Strategic rehabilitation and case management	Tight guidelines and processes to guide referral
	Targeted and short term rehabilitation
	Fast and informed decision making
	Ongoing risk assessment and management
	Strategic and outcomes-focused case management
	Holistic case management
	End-to-end case management
	Investment in training and development
Recruitment of the right capability	

More detailed information on each jurisdiction is provided in Appendix F.

3.2.1 Vocational rehabilitation provider monitoring, management and remuneration

WorkSafe Victoria has implemented some innovative strategies to improve the monitoring, management and remuneration of vocational rehabilitation providers, with the aim of promoting and rewarding timely return to work.

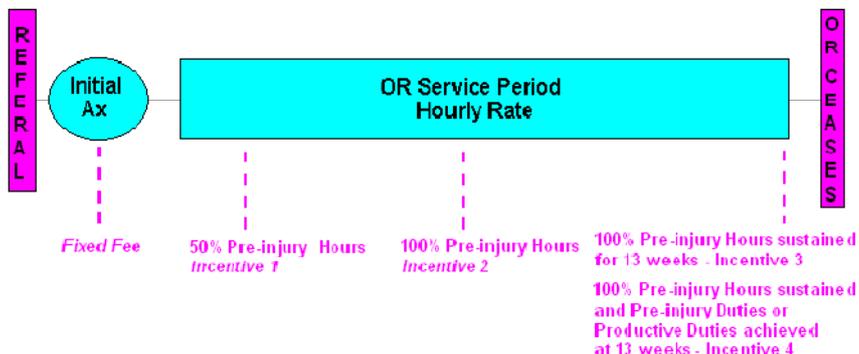
In terms of monitoring and managing the performance of providers, WorkSafe Victoria is concerned with actual return to work outcomes and has commenced publishing vocational rehabilitation provider results to act as an indirect incentive. In order to compare providers and measure outcomes in a relatively standardised manner, files are weighted based on certain criteria (eg timing of referral and complexity indicators such as whether the claim is for a psychological injury).

WorkSafe Victoria has also introduced a Clinical Review Panel to assess long term use of vocational rehabilitation services. The panel is made up of key clinical experts, including top performing vocational rehabilitation providers. The role of the panel is to assess cases that have vocational rehabilitation on them for greater than six months and question the vocational rehabilitation provider on the case regarding duration and issues. The current focus is on original employer services (OES), with positive results being noticed. Vocational rehabilitation on files greater than six months has reportedly reduced from 12 per cent to four per cent. The reduction in long term use of vocational rehabilitation services has also been realised through the use of OES incentive payments, which are discussed next.

Since 2008, WorkSafe Victoria has gradually introduced incentive payments for vocational rehabilitation providers delivering both OES and new employer services (NES). The OES model is unique in which a mixture of fee for service

and incentive fees are paid to vocational rehabilitation providers when substantial return to work goals have been achieved and sustained for the nominated period. Figure 9 below depicts this fee structure for OES.

Figure 9 Original employer services fee structure



Currently 15 to 20 per cent of payments are based on achieving outcomes. Stakeholders consulted stated they would like to see this performance-based component increase to 30 per cent, further incentivising providers to focus on return to work outcomes and reducing the duration of vocational rehabilitation on files.

The New Zealand Accident Compensation Corporation (ACC) is also exploring a new service delivery funding model for rehabilitation providers. Through this model, claims would be identified as either low risk or high risk with different funding model arrangements for each. For example, low risk claims would be screened and assessed for need and grouped into one of three categories. These categories have an associated level of funding, which would be allocated to and managed by the provider in order to achieve the relevant return to work outcome. Claims that are deemed to be high risk or complex have a more tailored approach, where case managers are responsible for selecting and referring for individual service components.

3.2.2 Regulatory oversight

The importance of proactive regulatory oversight and monitoring of a state's workers compensation system is paramount. This has been seen in SA with the Clayton report, in which a key recommendation emphasised the primary responsibility for the SA WorkCover system was to lie firmly within the WorkCover Corporation [6].

An increased level of risk is inevitable in any outsourced model, when compared to models such as Canada, New Zealand and Queensland, which are in-house and more tightly controlled and managed. WorkSafe Victoria; however, does appear to be introducing mechanisms to minimise the risk of an outsourced model, such as tighter monitoring and increased capability building. For example, WorkSafe Victoria requires the scheme agents to have a minimum capability structure (ie multidisciplinary teams) within the organisation to ensure appropriate support structures and expertise within the unit. As outlined in the previous section, WorkSafe Victoria also have 7 FTE allocated within their Return to Work Support Branch

The jurisdictions that have successfully kept case management and vocational rehabilitation within the regulator maintain close oversight of the workers compensation system and have dedicated resources internally to ensure systems and processes are in place to monitor the competence of staff and effective delivery of vocational rehabilitations services for durable return to work.

3.2.3 Capability building

WorkCover Queensland's introduction of the Ontrack philosophy to case management and return to work was teamed with extensive education and training for customer advisors. The training and education curriculum was aimed at reducing typical process driven case management by encouraging early decision making, verbal communication with NTDs, employers and injured workers, focusing on return to work outcomes and actively managing psychosocial factors over the life of the claim. In 2009, reported results indicated that 85 per cent of injured workers returned to work within six months of injury and the number of claims with a duration of greater than six months was reduced by 10 per cent.

The ACC has also recently focused on staff training and development through the introduction of a series of three hour and 12 week training programs for case managers.

WorkSafe Victoria is also following suit with the development of mandatory return to work training for case managers, in order to build expertise within the agent. WorkSafe Victoria is looking into vocational rehabilitation provider training, beyond what is outlined in the HWCA nationally consistent framework and considering including a requirement for providers to provide staff with 30 hours of training per year.

3.2.4 Segmentation and triage

Whilst the importance of segmentation and triage was highlighted earlier in this paper, the use of specific segmentation tools to assist triage coordinators within insurers was found to be limited.

The ACC has a segmentation model that streams claims according to complexity and risk; matching injured worker and claim need with case manager experience. The ACC's triaging structure is such that the short-term claim centre receives and processes all claims, considering demographic details and certified time off work information. Using this information, claims are initially triaged for initial contact and risk screening to either a:

- case coordinator– typically simple claims are triaged to the case coordinator who then contacts the injured worker and uses a set script to gather relevant information and undertake a high level screen for psychosocial flags. Case coordinators also receive support and advice from triage managers, as required
- triage manager (ie potentially complex claims) – potentially complex or high risk claims are streamed to the triage manager for initial contact, which includes identifying potential risks across psychosocial domains. Triage managers are generally expected to have a nursing or allied health (eg OT, physiotherapy) background or substantial experience as case managers. Although there is no set tool or questionnaire to guide the information gathering discussion, certain domains and standard questions are covered and triage managers are expected to be intuitive in their approach, given their experience and background.

Simple and low complexity claims are retained by the case coordinator within the short-term claim centre for administration and management; whilst high complexity claims are allocated by the triage manager to a case manager for proactive case management.

As in New Zealand, the Workers Compensation Board of British Columbia (WorkSafeBC) has a teleclaim contact centre, which processes and streams claims into three categories according to severity and time lost. Straightforward claims tend to be managed by client service representatives or entitlement

officers depending on the duration of time loss up to approximately four weeks. Management of more complex claims is undertaken by case managers.

In 2009, WorkSafe Victoria commenced a pilot project to improve agents' initial screening and triage practices and to better guide agents on psychosocial factors. WorkSafe Victoria developed a triage tool in the pilot project incorporating a small number of psychosocial questions for case managers to apply during their initial three-point contact process. The tool was designed to be relatively straightforward and easy to administer. Findings from the pilot showed that three of the six questions were reasonable in predicting length of incapacity (eg likelihood that a claim would reach beyond 26 weeks of time lost). Aspects of this new triaging tool are to be introduced into the upcoming new contracts with Agents in Victoria.

There are a number of tools, based on best practice research, available to potentially modify and apply to the risk assessment, triaging and ongoing management process. For example, the Örebro Musculoskeletal Pain Questionnaire (ÖMPQ) is a 'yellow flag' screening tool that predicts long-term disability and failure to return to work when completed four to 12 weeks following a soft tissue injury [20]. The screening tool enables stakeholders to identify possible risks factors and apply appropriate interventions to reduce the risk of long-term disability. The provision of an early assessment and intervention process can reduce costs in high risk claims. Evidence indicates that these factors can be changed if they are addressed early in the recovery process [21]. Although this tool is generally administered face-to-face, tools such as these could be modified for case managers to implement when talking with injured workers at the three point contact.

3.2.5 Strategic rehabilitation process

A number of jurisdictions interviewed structure their case management and rehabilitation model to optimise proactive management through ongoing risk identification and management, as well as sound decision making. The Queensland WorkCover Authority (WorkCover Queensland) and the ACC both have in common relatively low case loads (ie approximately 50 claims) and a requirement to undertake face-to-face contact with key stakeholders. This type of approach encourages tailored and holistic case management, which is focused on achieving good return to work outcomes for injured workers. Furthermore, the WorkCover Queensland model involves a collaborative approach between the customer advisor managing a claim and the rehabilitation and return to work coordinator at the employer site driving and monitoring the return to work. When necessary, specific, individual and one-off referral is made to rehabilitation providers (eg suitable duties assessment), with approximately 30 to 40 per cent of claims having a one-off assessment. However, the focus is on engaging and working with the rehabilitation and return to work coordinators to monitor return to work.

WorkSafe Victoria also understands the importance of having knowledgeable and experienced case managers managing a claim and overseeing the rehabilitation and return to work process. As such, the regulator requires scheme agents in Victoria to establish multidisciplinary teams comprising a case manager, technical manager and injury management advisor, for high risk claims. More recently, WorkSafe Victoria has contemplated introducing a return to work specialist role within each scheme agent to work on high risk files. This role would have relevant expertise to read provider reports, have open dialogue with providers and manage their performance.

WorkSafeBC also have a dedicated team that manages more complex claims; however, the WorkSafeBC approach is really underpinned by tight guidelines and processes around referral for vocational rehabilitation services (an in-house function). Through the WorkSafeBCs model, approximately five per cent of all time lost claims or 3,000 cases per year are referred for vocational rehabilitation services. On a similar theme, the WorkCover Authority of NSW (WorkCover

NSW) has outlined high level questions to assist case managers in undertaking early screening of rehabilitation need.

A study conducted by Canada's Institute for Work and Health (IWH) found that workers' claims can become prolonged because decision-makers involved in workers' recovery and return to work are not always in a position to fully understand workers' situations (eg the case manager) [22]. IWH has developed a guide *'Red Flags/Green Lights'* [23], which identifies problems that may develop during a worker's recovery or following return to work ('Red Flags') and provides suggested strategies ('Green Lights') to assist the planning of effective return to work processes. The guide is divided into four sections based on the context in which a 'red flag' might occur, ie: workplace-based problems; issues with the vocational rehabilitation process (eg retraining); health or medical management issues; and claim process and communication barriers.

In managing high risk and complex claims, most of these jurisdictions are structured such that the case manager role is driving the process, monitoring progress and outcomes, and remaining as the key decision maker. This is also the philosophy recently adopted by the Workplace Safety Insurance Board (WSIB) in Ontario, where a new service delivery model is coming into place from November 2010 (the 'work reintegration' program). All vocational rehabilitation services are to be brought back in-house with the case manager making referrals as necessary and remaining the decision maker throughout the process. The long term case managers, who are qualified and managing return to work and work transition services, once a file reaches six months, will be able to refer to internal work transition specialists. This position will support the case manager providing services and the employer is encouraged to contact the case manager to discuss the workers return to work and the services of the return to work specialists.

3.2.6 Other key elements for consideration

The areas discussed above tend to be within the control of the regulator and/or other relevant agencies. Although also important, the employer, NTD and injured worker are more difficult to influence. Key strategies and progress in other jurisdictions with respect to NTDs includes:

- a project initiated in 2008, designed to facilitate effective communication between WorkCover NSW and GPs. The implementation of the multi-modal strategy for engaging with GPs consisted of ways to ensure that GPs were being actively engaged and able to access resources and information designed to increase their understanding of the workers compensation system. The strategy included training and ongoing development, an information package, and a quarterly newsletter.
- the ACC has rolled out a pilot project *'Better at Work'* with a small number of GP practices. This program educates GPs on the benefits of work and staying at work. ACC is trying to encourage GPs to improve certification practices and change GP behaviours to encourage early return to work (ie certifying injured workers fit for suitable duties). This has involved working with the College of General Practice, conducting information sessions and presenting at conferences. The program is still being evaluated; however, the education is showing a change in GP certification practices. ACC is also looking into other incentive options, such as sharing proportion of income maintenance payment savings with GPs.
- WorkCover Queensland has a medical advisory panel consisting of specialists and GPs that are used when necessary to question medical information.

Appendix F provides jurisdiction summaries/overviews, as they relate to vocational rehabilitation.

4 Model options

Four model options for vocational rehabilitation structure and function are proposed and underpinned by a high level framework, based on key learnings from jurisdictions and best practice. A remuneration model for vocational rehabilitation is proposed, which is more focused on short term support and return to work outcomes.

4.1 Overview of proposed model options

Four model options for the structure and function of vocational rehabilitation are described in Table 3. However, regardless of the adopted model option, the system must be based on early intervention principles, clear and regular communication practices and a strong capability building approach to facilitate the provision of the right service, right time and right cost principle.

The remuneration framework of vocational rehabilitation providers needs to fit the selected model option, but as a basis, needs to be shorter, more focused, and provide incentives for successful return to work outcomes. Moreover, the system must be underpinned by key rehabilitation and return to work principles and elements – these elements have been used to present consultation themes and jurisdiction learnings in the previous sections. This high level framework is outlined below.

4.1.1 Underpinning framework

Performance management and remuneration

A model that incentivises strategic rehabilitation and realisation of return to work outcomes through rigorous monitoring and management mechanisms and an outcome-based remuneration structure.

This requires performance monitoring and management of vocational rehabilitation providers that is focused on return to work outcomes and considers the complexity of the claim (ie weightings depending on number of risk factors/barriers). It also requires the establishment of a group that examines the rehabilitation and return to work activity on claims greater than six months, which is similar to the Victorian clinical panel.

A blended payment model should also be considered, which includes fixed fee, hourly rate, and performance component based on return to work outcomes and durability (eg full RTW, partial RTW, sustainability at 13 and 26 weeks). Milestone and incentive payments should represent at least 15% of total remuneration, with an aim of increasing outcome component to 30% of fee. This is in line with the Victorian model, which allocates 15 to 20 per cent of payments to performance-based fees.

Capability building

Ensuring the right people have the right knowledge, skills and abilities to manage claims and facilitate return to work.

There are generally two ways to do this:

- Targeted recruitment and selection of suitably qualified personnel – for example, in New Zealand, case managers who work on high risk files are generally expected to have tertiary qualifications. Internal Vocational Rehabilitation Consultants in British Columbia are usually expected to have

a post graduate level qualification in counselling and professional certification

- A training and development program that builds the right capability – for example, Queensland has a strong training and development framework as part of their Ontrack approach. Victoria is also currently developing return to work training for case managers in order to build expertise within the Agent. In addition, there is a plan to introduce a return to work specialist role who would have the capacity and expertise to read provider reports and have open dialogue with providers.

Ideally a combination of the two methods would be implemented – ie a recruitment and selection strategy that brings in suitably qualified personnel and a training and development framework that builds ongoing capability.

Segmentation and triage

An organisational structure to facilitate the appropriate segmentation of claims into high and low risk groups, which are managed by suitably qualified and experienced people.

In this paper, high risk claims are predominantly defined as lost time claims with key risks identified or likely to be identified, which will most likely lead to delayed return to work. For example, where the injury is psychological in nature, the injured worker has previous or current claims or a conflict with a work supervisor, the pre-injury employer is a small business, or new employer services are required. However, it is acknowledged that some claims without lost time will also be high risk/complex and will require an experienced individual to identify and assess such claims and triage them accordingly. Low risk claims are those claims that will more than likely return to work with simple management and have no time lost or the injured worker will be back to work with some capacity within 10 to 15 days.

This type of segmentation model requires an appropriate approach to triaging claims into high and low risk groups to be managed by suitably qualified case managers. An example of where this type of model is currently in place and driving the strategic management of claims is the New Zealand approach. Through this segmentation and triage approach, claims are initially streamed to case coordinators and triage managers for risk assessment and subsequently triaged into simple and complex claims, which are managed by two different teams. British Columbia also triage claims into three segments based on lost time, severity and ongoing management requirement.

Similarly, case managers within the Victorian pilot are equipped with triage questions to administer to the injured worker and employer as part of the three-point contact process, in order to determine the likelihood that a claim will go beyond 26 weeks.

Strategic rehabilitation process

A process that achieves good return to work outcomes through strong linkages between case management activity and rehabilitation.

This involves a clear protocol for referral to vocational rehabilitation providers, which emphasis short-term and targeted early referral.

Focused end-to-end case management practice (ie across pre-injury and new employer environments) is important for maintaining a good relationship with the injured workers and other relevant stakeholders. It also encourages familiarity with a claim and in depth understanding of an injured workers situation. This mirrors the general approach within Queensland, New Zealand and Canada.

Within a strategic rehabilitation process, high risk claims are managed by capable individuals and face-to-face contact is with the injured worker and other key parties is required. Ongoing risk assessment through the use of appropriate

tools (eg OMPQ, Canadian Red Flag Green Light guide) facilitates fast and sound decision making. For example, customer advisors within the Queensland model manage high risk and complex claims through this type of process.

4.1.2 Proposed model options

Table 3 below describes the four model options, which should be considered in light of the framework described above. These models sit across a continuum of passive (ie recommendations focused on redistributing current resources in the framework) to more aggressive (ie require substantial change to organisational structure and operations, including roles and responsibilities) options. High level implementation considerations are also outlined.

Across the four models, the following recommendations are proposed:

- Strengthen WorkCoverSAs regulatory oversight role through increasing capacity (ie resources) in the VRU over a short term period. This will require consideration to the number of vocational rehabilitation providers to be approved going forward and where management of high risk claims will reside.
- Refine the vocational rehabilitation remuneration structure to more closely mirror the blended payment model in Victoria and currently available through the IJSP in SA. This involves fixed fee, hourly rate (minimal), and return to work outcomes (including durability) components for both pre-injury and new employer services. Within the outcomes/performance component, payments should occur at full and partial return to work, as well as when sustainable return to work is achieved for 13 and 26 weeks. Milestone and incentive payments should represent a target of 15% of total remuneration, with an aim of increasing outcome component to 30% of fee over several years. Incorporated into this model, a weighting system that recognises the complexity of certain claims and remunerates accordingly. This will be important to discourage any potential cream-skimming – ie where some vocational providers only take on the uncomplicated claims, where outcomes and milestones will be more easily achievable.
- The number of registered vocational rehabilitation providers should be reduced. A small pool of approximately 10-15 registered vocational rehabilitation providers may be appropriate considering the number of claims in SA which are genuinely likely to need vocational rehabilitation, based on other scheme experience. This should include specialist job seeking and retraining organisations/providers. The vocational rehabilitation provider procurement process is an area of opportunity for the SA scheme. Although it will go hand in hand with remuneration and performance management arrangements, the number of providers that are registered and therefore require evaluating and managing will influence the resource requirements of the VRU. It will be important to identify vocational rehabilitation providers achieving good outcomes.
- Maximising employer control and influence by further engaging and involving return to work coordinators at medium to large employers in the monitoring of return to work activity. This has the potential to reduce current vocational rehabilitation costs associated with pre-injury employer return to work monitoring.
- A requirement for providers to invest in the training and development of rehabilitation consultants in order to foster ongoing professional development and to strengthen the rehabilitation industry. The VRU needs to have a key role in overseeing the fulfilment of this requirement.

Table 3 Proposed model options

Option	Overview
Model 1	<p>This model is characterised by a strong claims agent presence, where:</p> <ul style="list-style-type: none"> • the claims agent is responsible for the active management of all claims . • claims are segmented into high and low risk, which is facilitated by an internal triage mechanism. • high risk case managers are suitably qualified and skilled for managing complex claims (ie similar to an internal rehabilitation consultant) and have a reasonable case load (eg 40 to 50 claims) to allow for proactive case management, including face-to-face contact with all parties. In order to test the fit of this, a pilot could be undertaken whereby a selection of case managers (either suitably experienced or with the support of a qualified individual) within EML and one or two other smaller insurers or administrators manage a sample of high risk claims. • high risk case managers within the claims agent are suitably experienced and skilled in regards to case management practice and return to work. • referral to external vocational rehabilitation providers is appropriate, short term and targeted (ie individual service components, which is similar to New Zealand’s service delivery funding model for high needs claims), with high risk case managers driving the process and monitoring progress and outcomes. For example, establishing a small team within EML to monitor vocational rehabilitation referrals that are persisting for longer than four to six months.
Model 2	<p>This model is characterised by a mixed claims agent and Regulator management approach, where:</p> <ul style="list-style-type: none"> • the Regulator is responsible for the active management of high risk claims and the claims agent is responsible for the active management of low risk claims, including the claims administration function of high risk claims. Given the significant change required to implement such a model, a pilot project may be undertaken to assess the feasibility. This could involve the VRU taking ownership of and managing a small sample of claims requiring vocational rehabilitation for returning to the pre-injury employer. • the claims agent receives all claims and is responsible for appropriate triage into high and low risk areas. Claims flagged as high risk are then required to be referred to the Regulator for management. The claims agent continues to manage low risk claims, by their low risk case manager. • referral to external vocational rehabilitation providers is short term and targeted – ie individual service components, which is similar to New Zealand’s service delivery funding model for high needs claims, as well as the approach in Queensland – with high risk case managers driving the process and monitoring progress and outcomes.

-
- Model 3** This model is characterised by a mixed claims agent and vocational rehabilitation provider management approach, where:
- the vocational rehabilitation provider is responsible for the active management of high risk claims and the claims agent is responsible for the active management of low risk claims, including the claims administration functions of high risk claims. As with model 2, this would involve a substantial shift from current practice. An option may be to select one or two high performing vocational rehabilitation providers to trial this provider-led management of high risk claims with a small sample of complex claims.
 - the claims agent receives all claims and is responsible for appropriate triage into high and low risk areas. Claims flagged as high risk are then required to be referred to the vocational rehabilitation provider for management. The claims agent continues to manage low risk claims, by their low risk case manager.
 - as part of the active management of high risk claims, vocational rehabilitation providers are responsible for all non-administrative aspects of the case and therefore also have financial/funding responsibility for the case.
 - in this model, vocational rehabilitation providers managing high risk claims are accountable to the Regulator.
-

Model 4 This model reflects little to no change from current activity in terms of the way claims are triaged and managed, and return to work outcomes realised. The additional recommendations noted previously in terms of underpinning principles are still applicable to this model option.

4.2 High level costing of options

4.2.1 Vocational rehabilitation remuneration

This report has found that in SA, vocational rehabilitation for the first two years post-injury represents an investment of around \$12m in current values. This investment is very high compared to comparable jurisdictions, and the return on the investment is poor.

It would seem that at least 20% to 30% of this expenditure could be recovered by eliminating the “monitoring” code from vocational rehabilitation, and requiring a more focused and shorter-term intervention (eg maximum six months with extension to nine or 12 months on review).

Part of the release of this \$3m to \$4m could be applied to an outcome incentive (in a number of stages relating to durable return to work), and an enhancement of capacity and capability within the VRU.

In our view this amended remuneration structure, together with a smaller and more focused vocational rehabilitation industry, would reap immediate benefits to the scheme.

Significant further reductions in overall scheme costs could be obtained by refocusing the claims agent referral and management structure, as discussed in the next section.

4.2.2 Structural model options for vocational rehabilitation

Further work should be undertaken to understand the high level cost and feasibility implications of the four model options presented above. The models requiring more structural changes are unlikely to be feasible for 12-18 months, but if this is the preferred course, planning can begin immediately.

In considering any cost implications, these should also be contrasted to the potential cost benefit to the scheme. The scheme review of 2007 identified that the SA scheme invested relatively less on its claims management costs than comparable schemes, considering the magnitude of outstanding claims liability and ongoing premium. The review also identified the financial leverage effect of achieving short-term discontinuance (ie supporting injured workers to return to work rather than remain on compensation).

In this context, with an annual premium of some \$600m, a reduction of 10% (which is very achievable based on experience in NSW and Victoria) provides a return of \$60m on any investment – hence the cost of the investment can be assessed within these parameters. However any such investment must be actively managed as discussed earlier in this report.

4.3 Implementation considerations and concluding remarks

As noted above, the underpinning framework is consistent across the model options; however, the method for delivering this framework varies from a simple redistribution of current resources, with limited change to the overall vocational rehabilitation structure, to more aggressive transformation to the service delivery arrangements and core roles and responsibilities.

Due to this continuum of options, it would be advantageous to test key components of the various models, through the development of specific pilot projects as presented above, prior to full adoption and roll out. This would provide additional evidence to support the selection of a particular model or hybrid model.

This review has identified a number of barriers to the realisation of durable return to work outcomes for injured workers. Although referral to vocational rehabilitation providers is a strategy adopted by agent case managers to improve return to work, the way in which rehabilitation is currently being referred to, monitored and generally kept on over the life of a claim is not conducive to reaching these desired outcomes. Rather, a strategic approach to identifying the need for rehabilitation intervention, which is underpinned by a targeted referral philosophy, as well as a remuneration structure that requires providers to perform well and achieve good return to work outcomes is necessary.

Appendices

Appendix A	Glossary	42
Appendix B	Interview schedules	43
Appendix C	Invitation letter	47
Appendix D	Statistics on SA	48
Appendix E	Data requests	49
Appendix F	Jurisdiction summaries	53
Appendix G	References	66

Appendix A Glossary

Term	Description
ACC	Accident Compensation Corporation
AFOEM	Australasian Faculty of Occupational and Environmental Medicine
Capability	In this report, refers to someone's ability in relation to knowledge, skills and understanding
Capacity	In this report, can refer to someone's physical and/or mental ability to work after an injury; or available time and resources
CAPO	Characteristic Adjusted Performance Outcome
DQ	Development quarter, which is the quarter following the injury quarter
EML	Employers Mutual
FTE	Full time equivalent
GP	General Practitioner
HWCA	Heads of Workers' Compensation Authorities
IJSP	Intensive Job Seeking Program
IMA	Injury Management Advisor
MDT	Multidisciplinary Team
NES	New Employer Services
NET	New Employer Transition
NSW	New South Wales
NTD	Nominated Treating Doctor
OES	Original Employer Services
ÖMPQ	Örebro Musculoskeletal Pain Questionnaire
RACP	Royal Australasian College of Physicians
RPL	Recognition of prior learning
RTW	Return to Work
SA	South Australia
SISA	Self Insurers of South Australia
Suitable duties	Short term modified, alternate or light duties that the injured worker can do until they are able to return to their pre-injury role.
Suitable employment	Employment for which the injured worker is suited to (at time of assessment) when they cannot return to their pre-injury role and/or employer.
TI	Total incapacity
VR	Vocational rehabilitation
VRU	Vocational Rehabilitation Unit
WCA	Work Capacity Assessment
WorkCoverSA	WorkCover Corporation of South Australia
WorkSafeBC	WorkSafe British Columbia

Appendix B Interview schedules

Rehabilitation provider

1. Please tell us a bit about your vocational rehabilitation experience
2. What vocational rehabilitation services/interventions do you generally provide (eg initial assessment, return to work monitoring, job seeking)? Do you provide services to both attached and detached injured workers?
3. Please describe your role in the vocational rehabilitation process?
4. What is the role of the employer in facilitating return to work? How is the employer engaged/involved?
5. How is your performance as a rehabilitation consultant monitored and measured?
6. Can you please describe the remuneration model for the vocational rehabilitation services you provide?
7. Expenditure on rehabilitation has increased over the years. Why do you think this is? Have you noticed a change in referrals, or in the expectations/requirements?
8. In relation to vocational rehabilitation, what do you see as the current challenges/barriers to durable return to work for injured workers?
9. In relation to vocational rehabilitation, what do you see as the current enablers to durable return to work for injured workers?
10. How could the vocational rehabilitation process be improved to facilitate durable return to work outcomes?

Case manager

1. Please tell us a bit about your case management experience
2. What services constitute vocational rehabilitation (eg initial assessment, return to work monitoring, job seeking)? Does this differ depending on whether the injured worker is returning to the same and/or different employer and/or job?
3. Please take us through the initial steps of the vocational rehabilitation process (ie from identification of rehabilitation need to referral).
4. Once a referral is made, how are rehabilitation and return to work outcomes documented, monitored and measured?
5. What is the role of the employer in facilitating return to work? How is the employer engaged/involved?
6. How is communication ensured throughout the rehabilitation process?
7. How and when are rehabilitation claims finalised?
8. How is your performance in meeting return to work outcomes measured and managed?
9. How is rehabilitation provider performance monitored and managed?
10. Are you aware of how rehabilitation providers are remunerated?
11. From your perspective, how effective are rehabilitation providers in achieving return to work outcomes?

12. Expenditure on rehabilitation has increased over the years. Why do you think this is?
13. In relation to vocational rehabilitation, what do you see as the current challenges/barriers to durable return to work for injured workers?
14. How could the vocational rehabilitation process be improved to facilitate durable return to work outcomes?

Employer

1. Please tell us a bit about workers compensation and return to work within your organisation?
2. What is your approach / role in facilitating return to work for injured workers?
3. Who are the key parties that you interact with (eg case manager, rehabilitation provider, injured worker)?
4. Thinking about your recent experience of the return to work process, what were some of the key challenges/barriers to durable return to work?
5. Similarly, in terms of your recent experience, what factors have contributed to a smooth and effective return to work process?
6. How would you change your current approach / role in the return to work process to facilitate durable return to work outcomes?
7. Expenditure on rehabilitation has increased over the years. Why do you think this is?
8. Do you feel that the current vocational rehabilitation framework in SA is effective in supporting IWs and employers in return to work?
9. How would you change the current vocational rehabilitation process within SA to facilitate durable return to work outcomes?

Injured worker

1. Please tell us a bit about your injury.
2. What is your current work status?
3. How long were you/have you been off work?
4. Please tell us about your experience with your workplace injury, particularly the return to work assistance that you have received/are receiving?
5. What are some of the key challenges/barriers that you have faced/are facing in returning to work? What did you find was/is unhelpful throughout the process?
6. What are some of the things that have helped/are helping you in the return to work process?
7. What has been/is your experience with the various stakeholders (eg case manager, employer, rehabilitation consultant)?
8. Does anything stand out as a major hurdle in the return to work process and potentially for other workers?
9. Does anything stand out as a major opportunity to improve the return to work experience for other workers?

Employee representative

1. Please tell us a bit about your Union and who you represent (ie. what main industries, registered or self-insured organisation) in SA?
2. What is your understanding of and your involvement in vocational rehabilitation within SA?
3. Please tell us a bit about the issues you come across in regards to workers comp and return to work?
4. How important is the employer - injured worker relationship in durable return to work?
5. What do you think are the key challenges/barriers that your members (Injured workers) face in the return to work process?
6. Similarly what factors have contributed to an effective return to work process for your members?
7. In your experience have external rehabilitation providers been of assistance to your member in return to work? How about case managers?
8. Do you feel that the current vocational rehabilitation framework in SA is effective in supporting IWs and employers in return to work?

Employer representative

1. Please tell us a bit about your organisation and who you represent (ie. what main industries, registered or self-insured organisation) in SA?
2. What is your understanding of and your involvement in vocational rehabilitation within SA?
3. Please tell us a bit about the issues your members experience regards to workers comp and return to work?
4. What is the role of the employer (your member) in the return to work process? How important is the employer – injured worker relationship in durable return to work?
5. What do you think are the key challenges/barriers that your members (employers) face in the return to work process?
6. Similarly what factors have contributed to an effective RTW process for your members?
7. In your experience have external rehabilitation providers been of assistance to your members in return to work? How about case managers?
8. Do you feel that the current vocational rehabilitation framework in SA is effective in supporting employers and their injured workers in return to work?

Jurisdiction representatives

1. Please tell us a bit about your role.
2. At a high level, how is vocational rehabilitation structured in your jurisdiction (ie key features, goals and targets)?
3. Do you feel that the current vocational rehabilitation framework is effective in supporting injured workers to return to work?

4. Have you noticed any trends in vocational rehabilitation expenditure over the last few years? How does this relate to return to work outcomes?
5. Has the approach to or focus on vocational rehabilitation changed over time in your jurisdiction? If so, why?
6. Please describe the regulatory structure within your jurisdiction.
7. What are the roles and responsibilities of the regulator, agent, rehabilitation provider, employer and injured worker? How about delegations of authority and autonomy?
8. What are the experience and capability requirements for agents (case managers) and rehabilitation providers?
9. What is the general process for referring to vocational rehabilitation? How are return to work outcomes set, monitored and measured?
10. How is workplace influence and control maximised to facilitate return to work?
11. How is communication and contact ensured throughout the rehabilitation process?
12. How are appropriate return to work timeframes met?
13. Please describe the remuneration model for vocational rehabilitation within your jurisdiction.
14. How does the remuneration model balance service delivery and realisation of return to work outcomes? How does it promote/incentivise tailored service delivery?
15. How are rehabilitation providers procured and what is the frequency of contract execution?
16. How is rehabilitation provider performance monitored and managed?
17. In relation to vocational rehabilitation, what do you see as the current challenges/barriers to durable return to work for injured workers?
18. What do you see as the key enablers (within the vocational rehabilitation process) of durable return to work outcomes?

Appendix C Invitation letter

Dear Ms/Mr _____

WorkCoverSA is looking at ways to improve how our services are delivered.

As part of the *Vocational Rehabilitation Review Project*, we have engaged PricewaterhouseCoopers, as an independent organisation to conduct interviews with a number of injured workers, employers, case managers and rehabilitation providers.

The purpose of the interviews is to:

- understand the current approach to vocational rehabilitation in SA and how it contributes to durable return to work outcomes
- ascertain the effectiveness of services provided by our contracted workplace rehabilitation providers (previously known as vocational rehabilitation providers)
- obtain learnings from other jurisdictions regarding key enablers and barriers to return to work through vocational rehabilitation.

You have the practical knowledge and experience of workplace rehabilitation service delivery to assist us in this process and we confirm your participation in an interview with PricewaterhouseCoopers. The interview will be by phone or video link and will not be recorded. You will be provided with a copy of questions to be asked prior to the interview.

Please be assured that any information you provide will remain confidential.

Monica Iglesias, a Manager from PricewaterhouseCoopers will contact you to arrange a time.

If you have any specific questions about the project, please contact Caitlin Francis, a Director from PricewaterhouseCoopers on +61 2 8266 1648 or caitlin.francis@au.pwc.com.

Yours sincerely

Rob Thomson
Chief Executive Officer
WorkCoverSA

Appendix D Statistics on SA

Table 4 SA statistics – population and locality

Population			Employed population*		Locality [^]
1,640,700 ⁺			811,500		Metro: 72.7%
Proportion 0 – 14 yrs	Proportion 15 – 64 yrs	Proportion > 65 yrs	Full time employed		Regional: 23.5%
			Males	Female	Remote: 3.0%
17.9% [#]	66.7% [#]	15.4% [#]	359,100 82.3% workforce	188,800 50.3% workforce*	

Source:

+ Australian Bureau of Statistics 3101.0 - Australian Demographic Statistics, 2010.

[^] ABS preliminary Estimated Resident Population, based on the 2006 Census of Population and Housing. (Located in Australian Bureau of Statistics 2008, Australian Social Trends, cat. no. 4102.0, ABS, Canberra.)

* Australian Bureau of Statistics 1345.4: SA Stats. 2010.

[#] Australian Bureau of Statistics 3235.0: Population by Age and Sex, Regions of Australia, 2009.

Table 5 Industry Groups in SA

Industry Groups	Number of employers	Number of workers
Blue collar industries	25,170 (43%)	232,069 (33%)
Service industries	15,496 (27%)	154,159 (22%)
Professional services	11,919 (20%)	114,640 (16%)
Govt and CommServ	5,879 (10%)	198,479 (28%)

Note: WorkCoverSA data was used for the following industries: Government Administration and Defence, Education, Health and Community Services, and Personal and Other Services. For all other industry sectors, the ABS Counts of Australian Businesses was used (Counts of Australian Businesses, including Entries and Exits, Jun 2003 to Jun 2007, Cat 8165.0, accessed 23 April 2010).

Table 6 National and SA employer and workers by employer Size

Size	SA		National	
	Number of employers	Number of workers*	Number of employers	Number of workers*
Small (< 20 employees)	52,143 (89%)	242,696 (33%)	815,985 (90%)	3,088,935 (28%)
Medium (20 – 199 employees)	5,869 (10%)	290,876 (41%)	80,554 (9%)	3,557,147 (32%)
Large (> 200 employees)	452 (1%)	190,255 (25%)	6,476 (1%)	3,171,318 (29%)

Source: Counts of Australian Businesses, including Entries and Exits, Jun 2003 to Jun 2007, Cat 8165.0, accessed 23 April 2010.

* There was some unknown data within number of workers which equated to 9% of the working population.

Appendix E Data requests

SA

Request 1: Utilisation of Vocational Rehab

19. Tabulation separately by the following employer groups
 - a. All non-exempt employers
 - b. Non-exempt small employers (2008/09 industry premium [base levy] <\$10,000)
 - c. Non-exempt medium employers (2008/09 industry premium \$10,001 to \$100,000)
 - d. Non-exempt large employers (2008/09 industry premium >\$100,000)
 - e. Exempt non-government employers
 - f. Exempt government employers
20. Tabulation for the following claimant definitions, as specified in sample spreadsheet
 - a. All claimants with injury date in 2008/09 financial year (by injury quarter)
 - b. Total incapacity claims (ie claims which receive some TI payment in the quarter)
 - c. Partial incapacity claims (ie non-TI claims which receive PI payment in the quarter)
21. Tabulation by the following payment types, as specified in sample spreadsheet
 - a. Weekly benefits
 - b. Vocational rehabilitation payments
 - c. Other payments (excluding Section 43)

Request 2: Detailed breakdown of Vocational Rehab payments by Code

1. Tabulation separately by the same employer groups as Request 1
2. Tabulation for the same claimant definitions as Request 1
3. Tabulation of Vocational Rehab payments by detailed Transaction Code, as specified in sample spreadsheet

Request 3: Detailed breakdown of Vocational Rehab payments by Number

1. All tabulations as for Request 2, but tabulation of Vocational Rehab payments by number per claimant, as specified in sample spreadsheet

Request 4: Premium paid

1. Total number of employers, total industry premium (base levy before bonus/malus), and total premium paid by the following employer groups
 - a. All non-exempt employers

- b. Non-exempt small employers (2008/09 industry premium <\$10,000)
- c. Non-exempt medium employers (2008/09 industry premium \$10,001 to \$100,000)
- d. Non-exempt large employers (2008/09 industry premium >\$100,000)

Employer Group:	Non-exempt medium									
Injury quarter:	Sep-08									
Payment quarter:		Sep-08	Dec-08	Mar-09	Jun-09	Sep-09	Dec-09	Mar-10	Jun-10	
Total claims injured in quarter	Sep-08	#								
Of the claims injured in this quarter:		#	#	#	#	#	#	#	#	
<u>Of these claims receiving weekly payments in quarter x ></u>										
<u>Total incapacity</u>										
N claims receiving total incap benefits		#	#	#	#	#	#	#	#	
Cost of total incap benefits		\$	\$	\$	\$	\$	\$	\$	\$	
<u>Of these:</u>										
N claims receiving Voc Rehab		#	#	#	#	#	#	#	#	
N transactions for Voc Rehab		#	#	#	#	#	#	#	#	
Cost of Voc Rehab		\$	\$	\$	\$	\$	\$	\$	\$	
Cost of other benefits/payments (ex S43)		\$	\$	\$	\$	\$	\$	\$	\$	
<u>Partial incapacity</u>										
N claims receiving partial incap benefits (and not TI)		#	#	#	#	#	#	#	#	
Cost of partial incap benefits		\$	\$	\$	\$	\$	\$	\$	\$	
<u>Of these:</u>										
N claims receiving Voc Rehab		#	#	#	#	#	#	#	#	
N transactions for Voc Rehab		#	#	#	#	#	#	#	#	
Cost of Voc Rehab		\$	\$	\$	\$	\$	\$	\$	\$	
Cost of other benefits/payments (ex S43)		\$	\$	\$	\$	\$	\$	\$	\$	

Employer Group:	Non-exempt medium									
Injury quarter:	Sep-08									
Payment quarter:		Sep-08	Dec-08	Mar-09	Jun-09	Sep-09	Dec-09	Mar-10	Jun-10	
Total claims injured in quarter		#								
Of the claims injured in this quarter:										
<u>Total incapacity</u>										
N claims receiving Voc Rehab		#	#	#	#	#	#	#	#	
N transactions for Voc Rehab		#	#	#	#	#	#	#	#	
Total Cost of Voc Rehab		\$	\$	\$	\$	\$	\$	\$	\$	
<u>Of these:</u>										
N claims receiving Transaction Code "A"		\$	\$	\$	\$	\$	\$	\$	\$	
N transactions for Transaction Code "A"		#	#	#	#	#	#	#	#	
Total Cost of Transaction Code "A"		\$	\$	\$	\$	\$	\$	\$	\$	
.....etc for all transaction codes										
<u>Partial incapacity</u>										
N claims receiving Voc Rehab		#	#	#	#	#	#	#	#	
N transactions for Voc Rehab		#	#	#	#	#	#	#	#	
Total Cost of Voc Rehab		\$	\$	\$	\$	\$	\$	\$	\$	
<u>Of these:</u>										
N claims receiving Transaction Code "A"		\$	\$	\$	\$	\$	\$	\$	\$	
N transactions for Transaction Code "A"		#	#	#	#	#	#	#	#	
Total Cost of Transaction Code "A"		\$	\$	\$	\$	\$	\$	\$	\$	
.....etc for all transaction codes										

Employer Group:	Non-exempt medium									
Injury quarter:	Sep-08									
Payment quarter:	Sep-08	Dec-08	Mar-09	Jun-09	Sep-09	Dec-09	Mar-10	Jun-10		
Total claims injured in quarter	#									
Of the claims injured in this quarter:										
Total incapacity										
N claims receiving Voc Rehab	#	#	#	#	#	#	#	#	#	#
N transactions for Voc Rehab	#	#	#	#	#	#	#	#	#	#
Total Cost of Voc Rehab	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Of these:										
N claims receiving 1 transaction	#	#	#	#	#	#	#	#	#	#
N transactions for claims receiving 1 transac	#	#	#	#	#	#	#	#	#	#
Total Cost of claims receiving 1 transaction	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
.....etc for the following:										
2-5 transactions										
6-10 transactions										
11-20 transactions										
>20 transactions										
Partial incapacity										
N claims receiving Voc Rehab	#	#	#	#	#	#	#	#	#	#
N transactions for Voc Rehab	#	#	#	#	#	#	#	#	#	#
Total Cost of Voc Rehab	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Of these:										
N claims receiving 1 transaction	#	#	#	#	#	#	#	#	#	#
N transactions for claims receiving 1 transac	#	#	#	#	#	#	#	#	#	#
Total Cost of claims receiving 1 transaction	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
.....etc for the following:										
2-5 transactions										
6-10 transactions										
11-20 transactions										
>20 transactions										

Other schemes

Request 1: Utilisation of Vocational Rehab

1. Tabulation separately by the following employer groups
 - a. All insured employers (ie exclude self-insured)
 - b. Small employers (2008/09 industry premium <\$10,000)
 - c. Medium employers (2008/09 industry premium \$10,001 to \$100,000)
 - d. Large employers (2008/09 industry premium >\$100,000)
2. Tabulation for the following claimant definitions, as specified in sample spreadsheet
 - a. All claimants with injury date in 2008/09 financial year (by injury quarter)
 - b. Total incapacity claims (ie claims which receive some TI payment in the quarter)
 - c. Partial incapacity claims (ie non-TI claims which receive PI payment in the quarter)
3. Tabulation by the following payment types, as specified in sample spreadsheet
 - a. Weekly benefits
 - b. Vocational rehabilitation payments
 - c. Other payments (excluding lump sum)

Request 2: Premium paid

1. Total number of employers, total industry premium, and total premium paid by the following employer groups
 - a. All insured employers (ie exclude self-insured)
 - b. Small employers (2008/09 industry premium <\$10,000)
 - c. Medium employers (2008/09 industry premium \$10,001 to \$100,000)
 - d. Large employers (2008/09 industry premium >\$100,000)

Employer Group:	Medium										
Injury quarter:	Sep-08										
Payment quarter:			Sep-08	Dec-08	Mar-09	Jun-09	Sep-09	Dec-09	Mar-10	Jun-10	
Total claims injured in quarter	Sep-08		#								
Of the claims injured in this quarter:			#	#	#	#	#	#	#	#	
Of these claims receiving weekly payments in quarter x >											
Total incapacity											
N claims receiving total incap benefits			#	#	#	#	#	#	#	#	
Cost of total incap benefits			\$	\$	\$	\$	\$	\$	\$	\$	
Of these:											
N claims receiving Voc Rehab			#	#	#	#	#	#	#	#	
N transactions for Voc Rehab			#	#	#	#	#	#	#	#	
Cost of Voc Rehab			\$	\$	\$	\$	\$	\$	\$	\$	
Cost of other benefits/payments (excl lump sum)			\$	\$	\$	\$	\$	\$	\$	\$	
Partial incapacity											
N claims receiving partial incap benefits (and not TI)			#	#	#	#	#	#	#	#	
Cost of partial incap benefits			\$	\$	\$	\$	\$	\$	\$	\$	
Of these:											
N claims receiving Voc Rehab			#	#	#	#	#	#	#	#	
N transactions for Voc Rehab			#	#	#	#	#	#	#	#	
Cost of Voc Rehab			\$	\$	\$	\$	\$	\$	\$	\$	
Cost of other benefits/payments (excl lump sum)			\$	\$	\$	\$	\$	\$	\$	\$	

Appendix F Jurisdiction summaries

NSW	
Population	7.1 million
Regulatory Framework	<p>The NSW workers compensation system operates under the <i>Workers Compensation Act 1987</i> and the <i>Workplace Injury Management and Workers Compensation Act 1998</i>.</p> <p>The workers compensation system is a public monopoly, with outsourced claims management to 7 private sector agents.</p>
Structure	<p>In NSW the case management structure within Agents consists of case managers and IMAs (Injury Management Advisors) who are allied health professionals within insurers providing technical support as well as training and development to assist in facilitating the proactive injury management within the claims team.</p> <p><u>Referral to rehab providers:</u></p> <p>The Agent has the discretion for referring to vocational rehabilitation. The NSW WorkCover Approval of workplace rehabilitation providers guide outlines the general aim of referral to rehabilitation providers [24]. This includes:</p> <ul style="list-style-type: none"> workplace rehabilitation providers are engaged to provide specialised expertise in addition to that generally available within the employer and insurer operations. workplace rehabilitation providers are engaged for those workers where a RTW is not straightforward. <p>WorkCover NSW lists some indicators to use in early screening activities for RTW coordinators and/ or insurer case managers for referral to workplace rehabilitation services. Some of these include:</p> <ul style="list-style-type: none"> do I have the skills, experience and resources to confidently manage the entire RTW process or do I require expertise from others? is the injury expected to be straightforward, with all medical advice received to date indicating recovery is going to plan? Or is the worker's presentation more complicated with recovery expected to exceed initial expectations and the timeframe normally associated with the particular injury type? are there any psychosocial factors present that may complicate or delay the RTW process e.g. workplace issues such as conflict between employer and worker, worker's attitudes and beliefs about his/her work capacity and willingness to return to work?
Performance management and remuneration	<p><u>Provider performance management:</u></p> <p>Providers are performance managed by both the Agent and WorkCover. The Agents often have a provider panel and manage the performance of providers. WorkCover performance manages on cost utilisation, RTW rates and also does onsite evaluations.</p>

NSW	
	<p><u>Agent</u></p> <p>WorkCover NSW collects individual performance data from each of the seven scheme Agents [25]:</p> <ul style="list-style-type: none"> • Long term treatment costs (growth p/a) • Duration (proportion of workers on weekly payments at 13, 26, 52, 134 weeks) • Timeliness of employer notification to agent (% received within 5, 12 days). <p>The Scheme Agent Performance Report provides information to employers and the public on the individual performance of the seven Scheme Agents in the NSW WorkCover Scheme. The report outlines the performance of Scheme Agents on the following measures:</p> <ul style="list-style-type: none"> • Claims Management and Return to Work • Service and Processing [26].
Other	<p><u>NTD education</u></p> <p>WorkCover NSW recognises GPs, in their role as NTD, play a pivotal role in the NSW workers compensation system. A project initiated in 2008, designed to facilitate effective communication between WorkCover NSW and GPs. The implementation of the multi-modal strategy for engaging with GPs consisted of ways to ensure that GPs were being actively engaged and able to access resources and information designed to increase their understanding of the workers compensation system. The strategy included training and ongoing development, an information package, and a quarterly newsletter.</p> <p><u>Procurement of providers:</u></p> <p>The HWCA endorsed a nationally consistent framework for the approval of workplace rehabilitation providers in June 2008 [27]. The workplace rehabilitation provider must comply with the Principles of Workplace Rehabilitation.</p> <p>An Instrument of Approval as a workplace rehabilitation provider will be issued for a three year period.</p> <p>The agents are able to put their own service standards on top of these.</p> <p>There are currently 100 providers in NSW</p> <p><u>Employers:</u></p> <ul style="list-style-type: none"> • Employers in NSW are responsible for providing a safe and healthy workplace. • The Workers Compensation Act 1987 provides that an employer shall not terminate a worker’s employment because of a work-related injury within six months of the worker first becoming incapacitated for work.

Victoria	
Population	5.5 million
Regulatory Framework	<p><i>Accident Compensation Act 1985 and Accident Compensation (WorkCover Insurance) Act 1993</i></p> <p>The Victorian workers compensation system is a public monopoly, with outsourced claims management to six (6) private sector agents.</p> <p>The RTW inspectorate, which can intervene if the employer or injured worker are not meeting their obligations. The RTW inspectorate mirrors the OHS inspectorate model.</p>
Structure	<p>WorkSafe Victoria requires each agent to establish multidisciplinary teams (MDTs) comprising a case manager, technical manager and injury management advisor to case manage high-risk claims.</p> <p>The case manager leads the team, acts as the primary contact for employers/workers, and manages the claim. The technical manager provides expert legal and technical advice to the case manager. The injury management advisor is responsible for developing and promoting injury management strategies that focus on early recovery and durable RTW.</p> <p>WorkSafe has a Clinical Panel – two (2) top performing providers run this service. If a file reaches six months of rehabilitation, the panel is responsible for checking in with the vocational rehabilitation provider to discuss the situation. This service has reduced rehabilitation on files over six months from 12% to 4%.</p> <p><u>Referral to rehab provider</u></p> <p>The Agent has the discretion for referring to vocational rehabilitation. WorkSafe does provide guidance within a framework. For example, the factors that may necessitate a referral to OES include [28]:</p> <ul style="list-style-type: none"> - Workers who have a current work capacity (CWC) but are not at work and require assistance to return to work - Workers who have returned to work on partial hours/duties and require assistance to return to full hours/duties - Workers at work full time who require assistance to graduate to pre-injury duties (PID) or productive duties - Workers who do not have a certified CWC however the circumstances of the claim suggest that a referral to OR would be beneficial and would assist in capacity creation <p>WorkSafe is looking a new model of 'targeted' early intervention when referring to providers. With the aim of vocational rehabilitation being independent targeted strategic intervention not case management</p> <p>Referrals to providers are still often based on relationships.</p> <p>Less than 33% (approx. 7000 to 9000) injured workers receive some form of vocational rehabilitation services.\</p> <p><u>Capability Building</u></p> <p>WorkSafe Victoria is considering looking into a training component within the new agent and provider contracts. In</p>

Victoria	
	<p>which WorkSafe will introduce RTW training for case managers which will be mandatory to build expertise within the Agent and 30 hours per year of training for providers within the life of the contract.</p> <p>Worksafe Victoria would also like to introduce skilled RTW specialist roles within Agents that would work on high risk files and measure and monitor files and providers. This specialist role would have capacity and necessary expertise to read provider reports and have open dialogue with providers.</p>
Performance management and remuneration	<p><u>Providers performance management:</u></p> <p>Providers are measured on actual return to work rates. In order to reflect more accurate reporting, the files are weighted on key aspects, such as time of referral and difficulty of case (complexity). The claims agent now publishes provider results, which provides greater transparency and serves as an indirect incentive for providers to perform well and realise return to work.</p> <p><u>Provider remuneration</u></p> <p>Fixed fee or hourly rates are negotiated between Agent and provider.</p> <p>Pay for outcome/ incentive system introduced 18 months ago. Incentives for both include:</p> <p>OES [29]:</p> <ul style="list-style-type: none"> • Incentive fee for 50% Pre-injury hours achieved • Incentive fee for 100% Pre-injury hours achieved • Incentive fee for 13 week sustainability achieved • Incentive for Pre-injury duties or productive duties achieved <p>NES [30]:</p> <ul style="list-style-type: none"> • RC890 Incentive <52 wks & no payments at 13 wks RTW • RC891 Incentive <52 wks & < 50% payments at 13 wks RTW • RC892 Incentive >52 wks & no payments at 13 wks RTW • RC893 Incentive >52 wks & < 50% payments at 13 wks RTW <p>In Victoria: 15 – 20% of payments are now based on outcomes. (would like to increase this to 30% - providers would then have to focus and rely on RTW focus outcomes)</p> <p><u>Agent:</u></p> <p>Monitoring of Agents through data collection – RTW rates at 6 months, continuance rates are also monitored. Success in RTW is closely monitored. The Regulator has monthly meetings with agent to look at performance.</p> <p>WorkSafe collects the following statistics on agents (these are publically available) to assess its performance for remuneration purposes:</p> <ul style="list-style-type: none"> - Duration (proportion of workers on weekly payments at 13, 26, 52, 134 wks)

Victoria	
	<ul style="list-style-type: none"> - Worker and employer satisfaction - Timeliness of employer notification to agent (% received within 12 days) - RTW plans (% received within 42 days) - RTW Coordinator training (% trained compared to target) - Long term treatment costs (growth p/a).
Other	<p><u>Pilot Project – triage and screening</u></p> <p>In 2009, the Victorian WorkCover Authority (WorkSafe Victoria) commenced a pilot project to improve agents’ initial screening and triage practices and to better guide agents on psychosocial factors. WorkSafe Victoria developed a triage tool in the pilot project incorporating a small number of psychosocial questions for case managers to apply during their initial three-point contact process. The tool was designed to be relatively straightforward and easy to administer. Findings from the pilot showed that three of the six questions were reasonable in predicting length of incapacity (eg likelihood that a claim would reach beyond 26 weeks of time lost). Aspects of this new triaging tool are to be introduced into the upcoming new contacts with Agents in Victoria.</p> <p><u>Procurement of providers:</u></p> <p>National consistent framework. Providers have to satisfy the national consistent framework plus extra requirements – particular benchmark requirements based around four (4) key themes: OES, NES, staffing/ qualifications and reporting). They are also going to add a measure around mandatory training (ie. Yearly professional development training).</p> <p>There are 37 approved providers in Victoria, with approximately seven (7) of those providers representing 80% of the workers compensation market. There are 12 providers that primarily offer new employer services.</p> <p><u>Employers</u></p> <p>RTW Coordinators introduced for businesses with > 20 employees. (once a claim exceeds 20 working days it is expected that a small employer will designate a RTW Coordinator within the workplace)</p>

Queensland	
Population	4.5 million
Regulatory Framework	<p><i>Workers’ Compensation and Rehabilitation Act 2003</i></p> <p>The QLD workers compensation system is a public monopoly, with in-house claims management delivered by WorkCover Queensland and self insurers</p> <p>The Queensland workers’ compensation industry is independently regulated by Q- COMP. Q-COMP is responsible for monitoring insurer performance and compliance across the industry.</p>

Queensland

Structure

In Queensland, claims are assessed in the claims determination centre which assesses claims and determines liability. Claims are then distributed to the Customer Services division who are responsible for rehabilitation, return to work and communications with the employer, NTD and providers. WorkCover QLD has 14 customer service centres throughout QLD so employers and injured workers have the flexibility to talk face-to-face with advisors.

The structure of the Customer Services Division includes:

- Short duration team who cover medical expenses only for 8 weeks, and files in which injured workers have been off work for less than 2 weeks.
- The Customer Advisors/ Senior Customer Advisors who are allocated claims that require ongoing claims management (ie. files that have > 4 weeks off work and medical expenses continuing for greater than 8 weeks). Customer Advisors drive the file and are aligned to specific employers and have a focus on good relationship management with employer. Where there are complexities they will refer for external rehab provider for individual one-off assessments.
- Customer Relations Managers: manage approximately 12 customer advisors.
- The Serious Injury Team: a small team looking after catastrophic injuries.

The customer advisor role is the main point of contact during a claim and coordinates rehabilitation and return to work. Customer advisors set goals and develops rehabilitation and a return-to-work plans. If the workplace has a return to work coordinator, they will be responsible for developing the plan with the help of the customer advisor (if needed).

In Queensland a new claims management process 'Ontrack' was introduced in March 2008. The focus was on early intervention and key features included: early decisions about claims, more verbal communication with NTDs, employers and injured workers, a focus on RTW and managing psychosocial factors that impact on claims outcomes. Extensive education and training was conducted to avoid 'process driven' RTW and a number of tools, eg 'Injury profiles' which identify red and yellow flags are now used by customer advisors.

In 2009, Ontrack helped WorkCover Qld return 85% of injured workers to work within six months and decreased the number of claims with durations of greater than six months by 10%. The average amount of weekly compensation paid also reduced by 11%, as a result of better rehabilitation and more prompt return to work [31].

Referral to rehab providers

Rehabilitation providers are brought in for specific individual one-off services (eg Suitable Duties assessment). As customer advisors have low case loads they are encouraged to meet face-to-face with the IW and employer either at the worksite or other arranged location. In straight forwards claims customer advisors will identify with RTW coordinators suitable duties. Reasons for engaging rehabilitation providers therefore include:

Queensland	
	<ul style="list-style-type: none"> • if suitable duties have not been identified • If pre-injury employment is not available (to look at transferrable skills), Skilling Solutions Qld (Government's free training and career information service (eg Certificate 3 etc) as well as state based voc rehab tool for training requirements for new jobs) • Vocational Assessment for job finding. <p>Approximately 30 – 40% of claims will have a one off assessment. Once an assessment has been conducted by a provider (eg suitable duties) the customer advisor proactively monitors the claim and RTW.</p> <p>WorkCover QLD also has a medical advisory panel consisting of specialists and GPs that are used when required to question medical information on claims.</p>
Performance management and remuneration	<p><u>Provider performance management:</u></p> <p>Currently providers are not measured on a RTW measure. Performance managed through ad hoc feedback – no defined quality measures (expectation is that providers will do good service).</p> <p><u>Agent monitoring:</u></p> <p>Monitoring is based on RTW outcomes including:</p> <ul style="list-style-type: none"> • RTW on SDs within 25 days • total average cost on claim below \$8,200. <p>WorkCover Queensland are aiming for a 92.5% RTW rate by Dec 2010.</p>
Other	<p><u>Procurement of providers:</u></p> <p>WorkCover Queensland has a state wide panel of providers.</p> <p><u>Employers:</u></p> <p>98,000 claims per year (30,000 to customer advisor area). Unsure of how many would go through to rehabilitation providers.</p> <p><i>Return to work assist</i> is a free Q-COMP initiative helping workers return to work. Services include a return to work assist advisor assisting with career planning, job readiness, free training (Government funded training programs are identified and workers are linked to registered training providers where they learn new skills to help them with their return to work goals) and RTW [32].</p>

New Zealand	
Population	4.3 million
Regulatory Framework	<p><i>Injury Prevention, Rehabilitation, and Compensation Act 2001</i></p> <p>The Accident Compensation Corporation (ACC) is a crown organization set by government to regulate and provide claims management in-house for all NZ residents and visitors to NZ.</p>

New Zealand	
	<p>The Department of Labour is the government department with responsibility for monitoring the performance of ACC.</p>
Structure	<p>The ACC has a network of 29 branch offices around NZ. ACC conducts claims management in-house. Once a claim is received the demographic details and any certified time of work certified are considered at the claim centre. The initial contact on a claim is then triaged to either a case coordinator or triage manager depending on complexity:</p> <ul style="list-style-type: none"> • Case Coordinators make initial contact on simple claims who interview applying a set script, and screen for psycho-social flags. • Triage Managers: are selected to provide proactive contact to the injured worker and have a conversation that looks at psycho-social domains. They do not need to follow a fixed tool, but do cover the domains, and have some standard questions. Triage managers often have a nursing, physio or OT background, or may be very experienced case managers. They also up skill coordinators and identifies issues on files. <p>After initial contact, claims are then classified to simple, low, high complexity. Simple or low risk claims are kept at the short-term claim centre with support and expert advice being delivered by the Triage Manager, and high complexity claims are referred to case managers for case management.</p> <p>Case Managers working on high risk files are expected to meet face to face with the injured worker in the branch office. Qualifications of case manager vary but are mainly university degree. Case Managers are monitored against case load and return to work standards. The case load for a case manager is currently 40 – 50 files (this used to be 60 – 80 files).</p> <p>The ACC has noticed an improvement in monitoring and RTW rates since lowering the case load for case managers. The 70 day return to work rates have improved by 5%, there has also been a reduction in external provider referrals.</p> <p><u>Referral to rehab providers:</u></p> <p>Case managers occasionally engage external providers for one-off services. Vocational rehabilitation focussed on return a injured worker to their pre-injury employer is purchased if there are risk flags that will benefit from a face to face meeting at the workplace, and ongoing service is approved if it is necessary to support gradual return to work.</p> <p>A small proportion of files are referred to vocational rehabilitation (approximately \$49 million per annum out of \$900 million on weekly compensation – which equates to \$1.8 billion per year on all claims).</p> <p><u>Capability Building:</u></p> <p>The ACC has recently started education programs to up skill staff in the form of a series of 3 hour and 12 week programs.</p>
Performance management and remuneration	<p><u>Provider Remuneration</u></p> <p>Currently funding arrangements vary depending on the service. Most services are a fixed fee for service, which can include an hourly rate. Some providers are reimbursed in accordance with regulated amounts outside of contracts. Two</p>

New Zealand	
	<p>vocational rehabilitation contracts have amounts that reward successful job placement.</p> <p>This is currently changing due to a recognised need to streamline and update the process. The ACC is moving towards shaping the services to meet ACCs new service delivery model. This new service delivery funding model includes different funding arrangements depending on the complexity of the claim:</p> <ul style="list-style-type: none"> • Low risk claims – if an IW needs support services from a provider, the IW will be grouped into one of three bands after screening and assessment. The claim will then come with an associated level of funding. The provider will need to achieve a RTW outcome with this ‘bucket’ of money. • High (complex) needs claim: will have an individual approach. Case managers will have a menu of services to choose from (moving from sequential to concurrent service approach) - providers will be referred for individual service components with the aim of a durable RTW. <p><u>Provider performance management</u></p> <p>The ACC currently looking into new monitoring arrangements of providers – currently no real measures and is ad hoc (ie. based around relationships and knowing which providers get results for repeat referrals). Currently program managers and relationship managers within a health purchasing group have responsibility.</p> <p><u>Scheme performance:</u></p> <p>The ACC has a service agreement with the Minister which includes performance measures and targets, and reports quarterly on progress, including rehabilitation rates.</p>
Other	<p><u>Procurement of providers</u></p> <p>ACC has 16 separate service contractors (500 vendors) – services developed in an ad hoc way over last 12 years. ACC is currently changing this to meet the needs of IWs as discussed below.</p> <p><u>Employers</u></p> <p>There is currently no employer obligation to bring IWs back to workplace with a reliance on goodwill of the employer and some wider benefits (eg an employer can get levy discounts if employers keep IWs on board. However, this currently does not take into account durability)</p> <p><u>NTD</u></p> <p>NZ has rolled out a pilot project titled ‘Better at Work’ with a small number of GP practices. This program educates GPs on the benefits of work and staying at work. ACC is trying to encourage GPs to improve certification practices and change GP behaviours to encourage early RTW (ie certifying IWs fit for SDs. This has involved working with college of General Practice, conducting CME presentations, talking at conference. The program is still being evaluated however the education is showing a change in GP certification practices. ACC is looking at options of sharing the income maintenance saving with the GP.</p>

British Columbia, Canada	
Population	4.5 million
Regulatory Framework	<p><i>Workers Compensation Act 2002</i></p> <p>WorkSafeBC, (the Workers' Compensation Board of BC) – is the regulator and insurer and has offices throughout Canada. WorkSafeBC manages all work-related injuries in-house</p>
Structure	<p>Claims are initially managed in the Teleclaim contact centre where claims are processed and triaged into three categories:</p> <ul style="list-style-type: none"> • No time lost – health care claim only. • Time-loss claim: for claims < three weeks, the claim is initially handled in the call centre by client service representatives. Claims > than three weeks are transferred to the entitlement unit, where entitlement officers adjudicate claims and facilitate return to work. • Time-loss case management: claims involving workers with non-traumatic activity-related soft tissue injury, catastrophic injury, severe brain injury, or a psychological injury are transferred directly to a case manager. For claims more than four to six weeks, or where it is expected there may be difficulties returning to work, the claim will be transferred to a case manager for ongoing management. <p>The case manager can refer to a vocational rehabilitation consultant for vocational rehabilitation services. Referrals to are divided into two categories:</p> <ul style="list-style-type: none"> - Immediate referrals are made when a worker has sustained a severe or catastrophic injury. - General referrals are made when the medical evidence shows that a worker's injury or condition will be a considerable barrier to the worker returning to employment. <p>Vocational rehabilitation consultants are highly trained staff that usually have a Masters level degree in counselling and professional certification. Their role is to help injured worker return to work with either their pre-injury or a new employer. They are managed by senior client service managers. Vocational rehabilitation consultants have specific levels of authority and able to manage the majority of cases, expenditures and approvals of vocational rehabilitation plans without reference to anyone else.</p> <p><u>Referral to rehab providers:</u></p> <p>Vocational rehabilitation services are generally provided in-house. Occasionally claims are referred to external providers for specific services. The board of Directors publishes a policy that guides vocational rehabilitation services. This policy sets out referral guidelines for vocational rehabilitation services [33].</p> <p>In practice, only cases that are unable to return to the accident employer are referred to vocational rehabilitation Services—about 5% of all time loss claims or 3,000 cases a year.</p> <p>Nearly 90% of workers injured and first paid in a twelve month period returned to work within that year or the two months following. Most of these workers return to their usual</p>

British Columbia, Canada	
	employment while some may return to modified work or modified work schedule.
Performance management and remuneration	<p>The Board of directors has made RTW for workers a priority. The current target for return to work is to achieve a 75% RTW rate on case closure for claims referred to vocational rehabilitation services. Currently rates in 2010 are at approximately 71%.</p> <p>The time from vocational rehabilitation referral to the completion of the initial vocational assessment is tracked and has been in the 15 day range for some time. Under the new claims management system, certain milestones are met. Since vocational rehabilitation payments are handled in the system, most cases will have biweekly updates on how the plan is progressing toward RTW.</p> <p>The performance of external providers is generally expected to match the performance of our internal staff. Work is monitored in accordance with the vocational rehabilitation procedures and is considered primarily an extension of vocational rehabilitation services offered internally.</p> <p><u>Provider remuneration</u></p> <p>For external providers, the fee guide and selection of providers is tailored to achieve the goal of suitable employment that maximizes the worker's potential and minimizes the system and human costs</p>
Other	<p><u>Procurement of providers:</u></p> <p>A list of approved providers is established and maintained centrally. Each qualifying provider must meet and adhere to WorkSafeBC standards. Since most services are delivered directly, this list is added to and amended as needed but is primarily focused on areas outside the lower mainland</p> <p><u>Employers</u></p> <p>Employers have no direct responsibilities under the legislation to return an injured worker to work (ie no 'mandatory reinstatement' provision in the legislation (as exists in many jurisdictions), although most do accommodate injured workers to return to their own job or a suitable and available alternative.</p>

Ontario, Canada	
Population	13.1 million
Regulatory Framework	<p><i>Workplace safety and insurance act, 1997</i></p> <p>The Workplace Safety and Insurance Board (WSIB) – is the regulator and insurer with in-house claims management and rehabilitation.</p>
Structure	<p>The WSIB is currently undergoing a major shift in the delivery of vocational rehabilitation services. Currently, vocational rehabilitation in Ontario is a mix of internal and outsourced delivery. From November 2010 all outsourced components, primarily being Labour Market Re-entry (LMR) services, are being brought back in house. A review of WSIB's LMR and</p>

Ontario, Canada

return to work programs in 2009 showed that lack of direct WSIB involvement in LMR hindered return to work and the effectiveness of programs. The report found that while providers had, for the most part, met the terms of their service level agreements with the WSIB they had not met expectations regarding employment outcomes. The WSIB is establishing a new integrated LMR and Return to Work program called the work reintegration program.

The new service delivery model aims to improve return to work and recovery outcomes and brings new roles to focus resources in specialised areas – the Return to Work Specialist (RTWS) impacting return to work and new structures within labour market re-entry (LMR).

The new case management process:

Claim are initially handled by case managers who determine initial eligibility, entitlement to ongoing health care and loss of earnings benefits/services and coordinate return to work services with the pre-injury employer. There are three types of case managers:

- Eligibility – case managers make entitlement decisions (2-4 weeks from registration of claim)
- Short Term Case Management (STCM) – case managers coordinate return to work and recovery process (up to 6 months)
- Long Term Case Managers (LTCM) - case managers oversee return to work, recovery and work transition services (6 months through to case closure/return to work or benefit lock in at 72 months)

Case managers use a triaging process developed in conjunction with the Institute of Work Health. Cases are classified based on the complexity of the case. This case differentiation ensures the greatest amount of time and resources are used on cases at risk of increased duration.

In STCM, case managers access Return to Work Specialists (RTWS) who provide return to work facilitation services at the work site. RTWS act as interventionists bringing the workplace parties together to develop a RTW plan. RTWS do not carry caseloads and do not have extensive knowledge of cases – they simply rely on facilitation skills to help the workplace parties work out a viable RTW plan (interventions are usually completed in one meeting).

When a case is prolonged and it is identified that permanent impairment is likely, the case goes is referred to the LTCMs (usually at 6 months post injury). In LTCM, Work Transition Specialists (WTS) support the LTCM, providing traditional vocational rehabilitation services. WTS carry a caseload and work with injured workers to facilitate RTW with the pre-injury employer. Throughout the process, the case manager remains the decision maker.

Case Managers generally have university education. Work Transition Specialists are required to have university undergraduate degrees in a related field and 2 years of Voc Rehab type experience. They can also have an unrelated degree if they have 4 years of Voc Rehab experience. We also require that new hires meet the minimum requirements to hold the designation of Registered Rehabilitation Professional. For more information please see web site for VRA Canada.

Ontario, Canada	
	<p><u>Referral to providers:</u></p> <p>Services are generally provided in-house, however if a referral is made to an external provider it is on a one off basis. When a in-house referred is made to the WTS, a comprehensive plan is developed - all plan development and monitoring is managed internally. While a work transition plan is active, both the WTS and case manager are involved in monitoring the progress of the case. The key to this model is the collaborative and complementary nature of the WTS and case manager relationship.</p>
Performance Management and remuneration	<p>The performance evaluation framework currently in development, however it will involve a comprehensive set of cost, process, customer satisfaction and outcome measures. Data is collected from various sources and a balanced score card approach for reporting and evaluation will be used.</p>
Other	<p><u>Employer</u></p> <p>There is currently no legislative requirement to bring an injured worker back into the workplace.</p>

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