CASE MANAGEMENT

Case management is a vitally important role in work injury systems. For many injured workers, perceptions of their case manager determine perceptions of the system as a whole. A systematic review of studies of workers' perceptions of insurers found that workers who develop a rapport with their case manager tend to think highly of the compensation system, whilst negative interactions cause workers to lose faith in both the case manager and the system overall.[52]

In this section, the following is addressed:

- Role of the case manager.
- Characteristics of case management systems that enable individual case managers to be efficient and effective.
- Factors that impede high-quality case management (staff turnover, bureaucratic systems).
- Importance of soft skills such as communication, empathy, persuasion and negotiation.

The discussion of case management practice that follows here is underpinned by an awareness that the behaviour of individual case managers is influenced by the expectations and directives of the organisation that employs them. The employing organisation (e.g. an insurer or other service provider) in turn responds to the financial incentives and culture set by the overarching workers' compensation scheme.

As participants in various workers' compensation systems around Australia and Aotearoa New Zealand, specialist OEM physicians see how the attitudes and approaches of workers' compensation authorities influence stakeholder behaviour. The structure of many workers' compensation systems means that this influence is particularly strong in relation to case management practice.

For example, if the financial incentives set by insurers are based on closing cases, claims management organisations will set case managers' KPIs accordingly. Under pressure to meet their KPIs, some case managers will, in words taken from an internal email between a real-life case manager and his/her direct manager in one jurisdiction, 'terminate away!' rather than take a supportive, worker-centred approach.[23]

In contrast, a workers' compensation authority might adopt a worker support model in principle, but in reality fail to provide adequate resources in terms of case manager numbers and expertise, and systems that support case manager effectiveness.[11] In theory the approach is good, but in practice it may be difficult (if not impossible) for individual case

managers to implement. There may well be a failure of case management, but individual case managers are not to blame.

The role of case management in workers' compensation

Ideally, insurance case management is a collaborative process of assessing need and planning and implementing the necessary supports to achieve quality, cost-effective outcomes in line with legislation.

Insurance case managers are employed by private insurers (Western Australia, the Northern Territory and Tasmania), public sector insurers (Aotearoa New Zealand, Comcare, Queensland) or claims agents contracted by insurers (New South Wales, Victoria, South Australia).

The responsibilities of workers' compensation case managers vary between jurisdictions too. Common duties include:

- Claims determinations.
- Decisions about access to treatment and rehabilitation services.
- Building relationships and effectively communicating with all claims stakeholders (e.g. injured workers, employers and service providers).
- Managing paperwork and other administrative aspects of claims.

Some challenges of case management

Case management has been described as a difficult and emotionally demanding job that requires strong interpersonal skills (including written and verbal communication and conflict resolution), good time management, problem-solving skills, a clear RTW focus and administrative efficiency.[20-23]

In most jurisdictions, case managers are expected to have some technical knowledge, such as an understanding of workers' compensation legislation, processes and systems, and enough medical knowledge to question workers' entitlement to medical treatment as appropriate. Case managers must also maintain effective interpersonal relationships with all claims stakeholders, despite varying levels of engagement, cooperation and goodwill. However, case managers have responsibilities that may reduce stakeholders' willingness to enter into a collaborative relationship. For example, the use of IMEs to contest diagnoses or treatment recommendations can cause tension between the case manager and the worker and/or the treating practitioner.[87]

Case managers' responsibilities vary considerably depending on the complexity of the case at hand. Complex cases are time-consuming and require greater levels of expertise than straightforward cases. However, complex cases are not necessarily allocated to experienced case managers, and mental health claims are not necessarily allocated to a case manager with expertise in that field.

Attempts have been made to allocate specialised case managers according to the stage of the claim (e.g. the eligibility determination stage, the RTW phase, and the long-term stage), with the terminology used varying between jurisdictions. Such approaches are likely to be well-intentioned but can have unintended consequences.

Researchers who interviewed injured workers with long-term claims and other claims stakeholders (e.g. healthcare providers, case managers, lawyers and mediators) in one jurisdiction noted that a staged approach used in that jurisdiction may inadvertently have exacerbated "the frequency of change in staff and number of claims managers that injured workers, employers and HCPs [healthcare providers] must deal with".[150] As a result, injured workers reportedly experienced more distress and received worse service (e.g. via repeated loss of knowledge about the claim and the claiming individual), while case managers experienced frustration and less job satisfaction. Such practices may also be a breeding ground for mistrust, with some injured workers and claims stakeholders forming the opinion that insurers rotated case managers to ensure that professional distance was maintained and claims costs contained.

However, the greatest challenge to continuity of care likely comes from high staff turnover amongst case managers. Injured workers in Australia may have multiple case managers over the life of a compensation claim. For some workers – especially those with complex claims – this is a stressful experience because rapport and claim history is lost whenever a change of case manager occurs. Treating practitioners also describe the frustration of being asked to submit a new report each time there is a change in case manager.[150]

Other systems issues may pose further challenges. For example, insufficient staffing, ineffective claims management software, negative culture, poorly designed processes and time-consuming bureaucratic demands make effective case management difficult, if not impossible.

There is little publicly available information about staffing within insurers. However, a 2014 review by the Aotearoa New Zealand Auditor-General detailed the number of case managers by claims segment within the ACC.[151] There were approximately 1700 case managers for 41,500 claimants at any one time. While simple arithmetic suggests this translates to a caseload of about 24 claims per case manager, the report indicates caseloads varied between 37 and 85 cases, depending on the location, the level of case

complexity and the level of staff skills and experience. The Auditor-General's report goes on to say that the average number of minutes spent on each claim varied by case complexity, from 22 minutes per week for the low-risk Recover Independence Service to 94 minutes per week for more complex cases under the stream known as Serious Injury Service. The ratio of full-time staff equivalent to managers was about six to one.

More complex cases are often referred to an external party, i.e., a workplace rehabilitation provider (also known as an occupational rehabilitation provider). Rehabilitation providers have tertiary qualifications in health, such as physiotherapy or occupational therapy. Rehabilitation counsellors have specific training in case management and coordination of RTW. Rehabilitation providers and rehabilitation counsellors coordinate RTW with the workplace and treating practitioners. In 2019, the Heads of Workers Compensation Authorities published an updated principles of practice for Workplace Rehabilitation Providers[152] that supports the use of therapeutic counselling for the management of biopsychosocial barriers to recovery and RTW.

The rehabilitation provider may need to work within a narrow framework set up by the regulator or insurer or may have wide latitude in how a case is approached. Referral to a rehabilitation provider is common for more complex cases, but at times busy case managers outsource cases simply to reduce unmanageable loads. Referral for RTW services is less common in Queensland, where the insurance case managers typically coordinate RTW activities.

A final challenge of case management is the lack of direct research into best practice implementation. There is a lot of evidence about case management principles and approaches that cause problems, but less evidence about what works.

How do case managers and case management systems influence recovery and RTW?

Direct impacts of case management practices on the health, recovery and RTW of injured workers are well established, with corresponding impacts on costs.[12,153]

Disability,[6,71] pain,[63] physical health, perceived fairness,[6,67] psychological health,[63,71,89] use of healthcare services,[68] rate of recovery from traumatic injury,[65] long-term recovery,[71] likelihood of RTW,[65] speed of RTW[73] and quality of life[66,71] all vary according to worker experiences of compensation systems, particularly the degree to which workers perceive their compensation experience to be fair and low in stress. The behaviour of case managers helps create these perceptions, which are key psychosocial determinants of health.[6,59]

In the 2018 Australian National RTW Survey, data showed that nearly one-quarter of workers (23% of the 2515 interviewed) reported a negative or neutral claims experience. A positive claims experience was strongly associated with returning to work after accounting for other influences (i.e. injury and worker characteristics, as well as workplace factors).[51]

In 2014, the Aotearoa New Zealand Auditor-General reviewed the case management approach of the ACC and found that ACC did not provide a consistent quality of service to claimants with different treatment and rehabilitation needs.[151] The conclusion was that the ACC needed a more claimant-centred approach, particularly for claimants with complex needs. A follow-up review in 2017 found there had been improvement in case management, but assessing the new model, termed Next Generation Case Management (underpinned by algorithms based on claims data, but not fully implemented) was deemed premature.[154]

For injured workers, consistency of case management is important. Qualitative research conducted amongst long-term injured workers and other claim stakeholders in Victoria showed how repeatedly briefing new case managers on the injury and the history of their claim can leave injured workers 'feeling unsupported, frustrated and confused about their responsibilities or entitlements and so unable to manage their own recovery'.[150]

In contrast, well-trained and adequately resourced case managers who stay with an injured worker over the course of their claim can promote RTW through a partnership approach. The case manager may help the individual overcome obstacles, offer support, provide relevant information about rights and responsibilities, and influence other scheme participants such as the employer or treating practitioner.[12] These approaches are particularly important for people with an elevated risk of delayed recovery and RTW, who may be anxious, unsure, unhappy about their work situation, or coping with other life challenges.

Effective case managers and best practice case management systems

Case managers

Case management should be procedurally fair, timely, proactive and supportive. As such, the attributes and skills of an effective case manager include:[20-23]

- Interpersonal skills to enable positive interactions with people in difficult situations.
- Ability to influence multiple scheme participants through verbal or written communication.
- RTW focus and attitude.
- RTW facilitation skills.

- Assessment skills.
- Cultural safety and awareness skills.
- Appropriate language skills.
- Trauma-informed safety and awareness skills.
- Organisational and administrative skills.
- Problem-solving skills.
- Conflict resolution skills.
- Time management skills.

Elements of best practice case management systems

Accurate risk identification and intervention. Best practice case management prioritises accurate early identification of the needs and risks of workers, targeting care accordingly and evaluating the results.[155]

Timeliness of claims determinations, wage replacement payments and treatment. Delays are linked to prolonged disability, worse RTW outcomes, the development of secondary injuries and strong feelings of injustice in workers.[23,25,52,59,63,70,71,73,89,156-161] Delayed claims lodgement and extended decision-making timeframes are associated with increased risk of longer disability duration.[162]

Responsive monitoring. Effective case management systems track worker progress, monitor biopsychosocial influences and proactively trigger intervention as required.[12,71,153]

Guidance and support for workers and treatment providers. Difficulties in understanding the requirements of the claims process cause stress, undermine recovery and may lead to a more adversarial mindset.[63,71] Active guidance from a trusted case manager is preferred,[52] although high-quality online information can reduce feelings of injustice too.[88] Treating practitioners – especially those who irregularly manage workers' compensation claims – may also benefit from case manager guidance in terms of roles, responsibilities and administrative requirements.[59,158,163,164]

Regular, effective communication. Poor communication practices are linked to negative recovery and RTW outcomes,[52,59,71,89] whilst case management initiatives that include empathetic, supportive, informative and individualised communication substantially reduce the number of days of compensation paid, total claim costs, total medical costs and the amount paid in weekly benefits.[12,153]

Minimal paperwork and other bureaucratic demands for case managers and other scheme participants. Arduous and repetitive administrative requirements leave little time for proactive case management. Administrative demands also damage workers' mental

health and recovery prospects and reduce cooperation between insurers and healthcare professionals.[59,63,71,87] Treating practitioners say that more paperwork leaves less time for therapeutic work, and reduces their willingness to treat compensable patients.[60,163]

Fair and transparent disputes, reviews and investigations. Adversarial contexts result in poorer health outcomes for injured workers, lower rates of RTW and more negative emotions for stakeholders.[67,71,165] Ideally, IMEs are meant to assist with questions about diagnosis, causation, management and prognosis, and apply evidence-based medicine. However, in reality IMEs are frequently a source of tension, distrust and conflict in the RTW process,[52,166,167] and may delay recovery.[23,63,87,166] Other investigative processes also cause stress and humiliation for injured workers, compromising recovery.[23,89] Fair and transparent processes, with open sharing of information between stakeholders, are likely to build trust and safeguard engagement.[63]

Cooperation/capacity for multidisciplinary action. Best outcomes are achieved via multidisciplinary interventions.[26,168] Promotion of cooperation amongst stakeholders is an important part of case management.[169] This may include the provision of resources to enable key stakeholders to participate (e.g. payment for treating practitioners), noting that currently case managers cannot universally approve payments for multidisciplinary interventions.

Mental health. The limited available research on psychological claims suggests work injury schemes benefit from a best practice framework covering:[30]

- Developing the management practices for psychological claims.
- Optimising claims management teams.
- Engaging and supporting employers in the recovery at work/RTW process.
- Bringing evidence to treatment and rehabilitation.
- Effective decision-making supported by analytics and automation.
- Recording progress.

Transition support. Workers exiting the work injury scheme may not have resumed work. Transition support to assist workers navigate their next steps has shown promise, providing holistic care that is not constrained by the legislative limits of the compensable system. A pilot program in Victoria, developed through the Collaborative Partnership, is considered to have achieved over $10 million in potential savings via reduced Commonwealth Government benefits that were expected as workers transitioned from benefits in one scheme to benefits in another scheme, as well as aiding those workers.[170]

Barriers to improvement

Gaps in knowledge

Much remains unknown about effective case management in the context of workers' compensation. How much time should a case manager be allocated for simple versus complex cases? What competency-based training makes a positive difference? What is an appropriate division of time between compliance activities and proactive case management? How much of the role should entail influencing others, for example, upskilling a workplace in evidence-informed injury management to streamline the management of future cases?

Yet, there are no definitive answers to these questions – which is not to say there is no information about positive approaches. For instance, behavioural approaches in arranging IMEs have shown promise in improving the experience of the injured worker and securing cost savings.[144] There are many such opportunities for improvement, which stakeholders currently discuss in an ad hoc fashion.

What is lacking is an overarching structure for sharing successful case management strategies. In fact, the human and economic cost of work injuries may justify the establishment of a research institute for case management. Such a centre could facilitate the research, discussions, meetings and forums necessary to identify effective case management approaches. Options for funding the transition to evidence-informed practice include National Health and Medical Research Council (NHMRC) Partnership Projects, NHMRC Centres of Research Excellence, Australian Research Council (ARC) Industry Linkage Projects, Cooperative Research Centres, and the ACC in Aotearoa New Zealand.

It would also be helpful to have a data-driven understanding of factors that affect the quality of case management services. Annual reports on the state of the claims management workforce would help guide future improvements in this area.

A belief in quick fixes

While there have been difficulties in establishing quality case management practices in many jurisdictions over the last 30 years, recent reports have highlighted (and, importantly, provided novel data) on the state of case management in some parts of Australia. These highlight the state of case management practices that are contrary to the principles of evidence informed case management.

A 2019 Ombudsman's investigation into case management practices concluded:[10]

Agents are still unreasonably terminating complex claims: cherry picking evidence, doctor shopping, relying on Independent Medical Examiners (IMEs) over treating medical practitioners even when evidence is unclear, contradictory or inconclusive – or ignoring it if it didn't support termination.

The workers affected in the cases we reviewed included nurses, teachers, police officers, aged care and childcare workers, truck drivers, baggage handlers and tradesmen. The emotional toll was unequivocal; the cost not only to them and their families, but to society, should not be underestimated.

A 2019 review of the main insurer in another large jurisdiction found case management gaps had resulted in a notable deterioration in RTW rates and underwriting losses.[171,172] Problems identified included:

- Poor file management, and poor understanding of and skills required for compliance with legislation and best outcomes.
- The claims agent's workforce had been below the approved capacity due to ongoing recruitment difficulties.
- Case management was based on early triage into risk categories: 40% of the reviewed files were allocated to the wrong support category, resulting in delays.
- A focus on recruiting staff with customer service skills resulted in a lack of the skills and experience required for the technical case management of claims.
- Claims agents' financial incentives did not encourage proactive case management. Only 1% of the agent's remuneration was for RTW outcomes.
- The information technology (IT) system was difficult to use, with no master data catalogue for each file, making it difficult for claims managers to learn what had occurred in relation to the assigned claims.

The details of the 2019 reviews are included here because they highlight the many challenges to and importance of effective implementation. Note that in both jurisdictions, the relevant organisations accepted the reviewer's recommendations and are seeking to make improvements.

The use of KPIs in case management and health can and has led to perverse incentives and unintended consequences.[173] KPIs have been shown to encourage a short-term focus and to be 'gaming the system'.

Over the decades, various schemes have trialled different systems: in-house case management, outsourcing to one private claims agent, outsourcing to multiple claims agents, running private schemes, in which the private insurer carries the financial risk, and varying incentive arrangements to foster good claims agent practices. No one approach stands out

above the others. What does stand out is the need for a stable workforce of trained and experienced case managers who are supported to provide evidence-informed case management. Current approaches in some jurisdictions do not achieve this aim.

Systemic obstacles to effective case management

Inadequate support. Some case managers are not supported to cope with the emotional demands of the role.[22]

High turnover of case managers. Anecdotally, turnover is 40% per annum in some case management organisations in some jurisdictions. When turnover is high, continuity of care for injured workers becomes very difficult to provide.

Absence of standard training requirements. There is no standardised training for case managers, either within jurisdictions or nationally. This is at odds with comparable roles that involve assisting vulnerable Australians, including childcare and aged care. Further, training in human (soft) skills such as active listening is inconsistent.

Overwhelming caseloads. Thirty-five cases per case manager effectively means an allocation of one hour per case per week. Dealing with a complex case may take many hours in a week, yet there are reports of caseloads of 70–100 in some jurisdictions. In Aotearoa New Zealand, the ACC is currently trialling new approaches to claims management.

Inconsistent conditions and salaries. There is significant variation in conditions and salaries paid to case managers across the country, affecting both skill levels and retention. Case managers with experience have many opportunities to move into other roles with better conditions, such as working for self-insurers, directly for employers or moving into the life insurance sector. The cost of paying case managers well and developing the workforce is substantial; however, this needs to be compared to the costs associated with poor claims management practices.

Bureaucratic processes. Bureaucracies typically impose many requirements, and in some jurisdictions case managers say administrative requirements take precedence over case management activities, leaving little time to speak with injured workers or be proactive.

Lack of effective IT software. Case managers may lack software that is user-friendly and supports case management activities.[172]

Lack of research in case management implementation. Despite a shared understanding of the principles of effective case management, there is not yet sufficient research on

practical implementation approaches. Industry innovators have begun to partner with researchers to fill this knowledge gap (e.g. Recovery Blueprint[174,175] and the PACE project[176]). More such initiatives are needed.

Funding limitations. Attempts to control the costs of claims administration can lead case managers to rely on other scheme participants for everyday case management activities.

Reliance on claims investigation processes known to cause harm. Independent medical examinations and surveillance of injured workers can delay recovery and cause considerable stress. Whilst questionable claims should be investigated, the potential benefits of investigation must be weighed against known risks. Repeated requests for IMEs have been seen as a form of doctor shopping by case managers in some jurisdictions.[10]
A review of healthcare interactions following work injury found that workers forced to attend multiple medical assessments with no therapeutic value (e.g. IMEs) developed adversarial relationships with their case managers. Other research has shown that compensation recipients who undergo medical assessment are less likely to perceive the process as fair than those who aren't assessed.[67]

Workers with long-term claims and scheme providers have indicated pending a claim for investigation is routine for some types of claims, such as mental disorder claims. It is suggested that investigating workers and the circumstances of the claim can contribute to an adversarial and distrustful atmosphere.[150]

The needs of Māori and Aboriginal and Torres Strait Islander workers

There are significant gaps between the health of Māori and Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians and European-New Zealanders. These gaps are linked to experiences of historical trauma related to colonisation, including violence, loss of culture and land, and ongoing policies that perpetuate inequities in both countries. These issues affect Māori and Aboriginal and Torres Strait Islander workers in the workplace.

Māori workers have greater exposure to occupational risk factors than non-Māori. They make up 15% of the population[177] but only 8% of ACC claims in Aotearoa New Zealand.[178] Disparities for Māori include higher rates of serious/fatal injuries on the roads, lower GP referral rates to medical/surgical specialists, finding the claim process more complicated and ACC less helpful in their RTW, and lower rates of employment participation after serious injury.[179]

It has been recognised that Aotearoa New Zealand's health system does not meet the needs of Māori.[179] By extension, mental health and advocacy services face similar issues, in that they are not reflective of Kaupapa Māori (Māori world views and values). This can make it harder for Māori to RTW and is a significant factor that should be considered in the design of workplace injury schemes.

In Aotearoa New Zealand, the health of Māori is a right guaranteed by *Te Tiriti o Waitangi/Treaty of Waitangi*. Te Tiriti o Waitangi's underpinning principles are:[180]

- **Partnership**, which involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- **Participation**, which requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.
- **Protection**, which involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

As outlined in a 2015 ACC report:

> *Māori service delivery, particularly health service delivery, emphasises the importance of having a holistic view of health incorporating spirituality and whanau ties, a focus upon community and community taking ownership, provision of leadership that has integrity and an ability to build and/or utilise strong community networks.*[181]

The same ACC report outlines five key expectations of Māori regarding services in Aotearoa New Zealand:

1. **Fairness** – a system must achieve fair outcomes for Māori and all New Zealanders.
2. **Choice** – all choices must be fair and open.
3. **Improvement of services** – disparities must be addressed within both the larger healthcare system and ACC.
4. **Kaupapa Māori** – Māori world views and values must be respected and integral to the design and delivery of ACC services for Māori.
5. **Consultation and communication** – in the absence of genuine interaction and co-development/co-design, no changes to services will be successful in improving Māori trust and confidence in an organisation or the utilisation of services.[181]

As a Crown entity, ACC is responsible for actively supporting Crown obligations under Te Tiriti o Waitangi. ACC is currently developing new Kaupapa Māori Health Services. Its website advises that it is "working in new ways to ensure injured Māori have greater access

to services, improved experiences of ACC care, and better health outcomes" and "to provide whānau with a choice of services that deliver culturally appropriate care and uphold our responsibilities to Te Tiriti o Waitangi".[182]

Aboriginal and Torres Strait Islander peoples represent 3.3% of the total Australian population,[183] and many work in high-risk industries. In 2016, the main industries or sectors of employment for Aboriginal and Torres Strait Islander peoples aged 15–64 were healthcare and social assistance (15%), public administration and safety (12%), education and training (10%) and construction (9.5%).[184] From 2011 to 2016, the number of Aboriginal and Torres Strait Islander peoples who recorded in the Census that construction was their industry of employment grew by 28% – from 11,800 in 2011 to 16,200 in 2016.[185]

There is a significant gap between indicators of health and wellbeing for Indigenous and non-Indigenous Australians, including a shorter life expectancy, higher infant mortality, poorer health and lower levels of education and employment.[186] In 2018, the Indigenous employment rate was around 49%, compared with approximately 75% for non-Indigenous Australians.[187] These disparities are directly linked to experiences of trauma related to colonisation, including violence and loss of culture and land, policies such as the forced removal of children, and new instances of trauma.[188]

Aboriginal and Torres Strait Islander peoples do not have equitable access to care and treatment. The Royal Australasian College of Physicians has developed principles to inform and support the equitable provision of high-quality, effective, accessible, affordable and culturally safe specialist medical care. These principles represent a standard that should be adopted by funders, facilitators and service delivery organisations. They are:[189]

- Indigenous leadership.
- Culturally safe and equitable services.
- Person-centred and family oriented.
- Flexibility.
- Sustainable and feasible.
- Integration and continuity of care.
- Quality and accountability.

These principles can also be applied in Aotearoa New Zealand to provide high-quality, effective, accessible, affordable and culturally safe specialist medical care to Māori. Similarly, the needs of workers who are culturally and linguistically diverse and work in high-risk industries need to be acknowledged and met to reduce the disparities they face in health outcomes.[190]

Action areas

Accurate, responsive systems to deal with cases at risk of prolonged disability

Case management systems are one avenue by which workers' compensation systems can identify and manage the psychosocial risks of individual claims. Ideally, each organisation managing claims should undertake early screening and identification of high-risk cases. Each organisation should also have a strategy in place to address psychosocial obstacles to work including:

- Referral for therapeutic counselling.
- Referral for extra external assistance.
- Early input from specialist OEM physicians.
- Education and engagement in the workplace.

Claims investigations (including IMEs and surveillance) have health risks. They should be managed with care and sensitivity, particularly for workers at risk of prolonged disability.

Better recruitment, training and retention of case managers

The cultivation of a skilled, experienced workforce of workers' compensation case managers should be an urgent priority in every jurisdiction. Many things could be done to improve the recruitment, training and retention of case managers.

Recruitment. Arguably, workers' compensation case management is best understood as a helping or caring role. Therefore, case managers should be recruited with the understanding that the purpose of the role is to help people in a time of need. Other beneficial skills and aptitudes (e.g. communication skills, time management and administrative proficiency) should also be considered.

Training. Case management is a technically demanding role. As with aged care, it may be appropriate to develop a nationally accredited course (such as a Certificate III or IV) that standardises training, with encouragement for Diploma and Bachelor level studies. (An Aotearoa New Zealand Certificate in Case Management (Certificate Level V) exists already.[191]) Such a course would help ensure that case managers understand the principles of evidence-informed care, including awareness of the impact of psychosocial factors on RTW and recovery. However, differences in legislation between jurisdictions would need to be considered.

Retention. Options that may improve retention of case managers include:

- Improving pay and conditions in some jurisdictions.
- Clarifying and publicising career pathways for case managers, including advancement into complex case management, technical work, team leadership roles and management roles.
- Developing a system of mentors, for transfer of knowledge, support and connection.
- Recognising the emotional demands of the role, with commensurate human resource strategies to sustain case managers.
- Aligning perceptions and reality (i.e. ensuring that if case managers are recruited on the basis of wanting to help others, the role actually allows them to do so).
- Conducting an annual survey of case managers in each jurisdiction to understand whether they have the resources to do their job effectively and efficiently, without undue stress.

Consistency and specialisation

In addition to the retention strategies described above, case management systems should be structured to promote continuity of care. Workers report that changes in case managers occur frequently and hamper their claims.[150]

Segmentation of claims into short, middle and long term (or any similar designation), with transfer of the injured worker to a specialised case manager according to the stage of the claim, should be avoided. However, some specialisation in case management may be appropriate. For instance, it may be useful to have case managers who specialise in claims for psychological injury or in assisting workers identified to be at high risk of delayed recovery and RTW.

When specialisation is preferred, efforts should be made to promptly match injured workers to an appropriate case manager and secure continuity of care thereafter. It is also important to monitor and assess such measures to ensure they meet the needs of injured workers and improve job satisfaction amongst case managers.

Greater transparency regarding case management resources, costs and approaches

Assessing the impacts of changes to workers' compensation service delivery is notoriously difficult; these are very complex systems, making it hard to pinpoint cause and effect. This difficulty is exacerbated by the paucity of accurate, comprehensive data on case management resources, costs and approaches.

Using consistent methods and measures where possible, all jurisdictions should consider publicly reporting:

- Average claim numbers per case manager.
- Annual rates of staff turnover.
- Full costs of case management, including the costs associated with workplace rehabilitation providers and other outsourcing that occurs, especially when this outsourcing results from inadequate resources within the system.
- Case managers' views on whether the system they are working within supports evidence-informed RTW practices.
- Case managers' own job satisfaction, workload etc. (i.e. the psychosocial safety climate of case managers).

Recognising the need for culturally appropriate responses

There is a need for significant improvements in the workers' compensation and health systems for Māori workers, Aboriginal and Torres Strait Islander workers and other workers who have reduced access and greater needs in rehabilitation. Reducing disparity should be a priority for all workers' compensation systems.

The ACC in Aotearoa New Zealand has explicitly identified reducing disparity as a priority. Approaches to address disparity include building organisational capacity, establishing and building partnerships with relevant groups, and embedding cultural responsiveness within the system.[181] Outcome measures include fewer fatal/serious injuries, better employment participation after injury and new partnerships. Important approaches to improve equity include:

- Acknowledging that mainstream service provision alone is insufficient.
- A deep organisational commitment to responding to Māori.
- Better funding and longer-term commitment to Māori programs to ensure success.
- Applying the evidence for effective responses to Māori reported in the literature.[181]

Australian jurisdictions could do more in this regard.

National principles of practice for insurer case management

There is a need to clarify the responsibilities of case managers within workers' compensation systems and identify the key competencies and skills (including human or 'soft' skills) required to meet those responsibilities. One potential way forward is the development of a set of national principles of practice for insurance case managers, informed by the biopsychosocial model of health and recovery. The *Principles of Practice for Workplace*

Rehabilitation Providers,[152] endorsed by the heads of workers' compensation authorities in September 2019, could provide a template for such a document.

Note that any principles of practice must shape practice within all levels of relevant organisations (i.e. insurers and other providers of claims management services), not just the practices of individual case managers. Workplace and systemic factors such as feedback from managers, internal systems, KPIs and financial incentives must all promote evidence-informed case management, focused on worker care.

Better research, more leadership

Research

Targeted research is needed to inform case management practices in workers' compensation. Useful topics would include:

- Training needs of case managers, notably the skills and capabilities needed, as well as the best ways to meet those needs.
- Causes of the high turnover of insurance case managers and ways to reduce turnover.
- Comparative studies of case management approaches and outcomes across jurisdictions, looking at variables such as:
    - allocation of complex versus simple cases; and
    - time spent on compliance activities versus proactive case management.
- Evaluation of pilot program initiatives to test out different approaches, noting that there is some ongoing research in this vein (e.g. the PACE project[176] and Project Blueprint[174]).
- Cost-effectiveness of extra early support to prevent long-term disability.
- Most effective case management team structure: the level of allied health, injury management advisers and medical care support for case managers, basing team structure on claim duration versus the employer's type of industry, specialised teams for mental health claims or regionally based employers.
- Behavioural interventions that streamline communication between claim stakeholders.
- Testing various approaches to support people at high risk of delayed recovery and RTW.

The views of case managers should be integral to developing effective case management systems.

Leadership

The complex questions around case management arrangements would be well served by the creation of an ARC-funded Centre of Excellence for research into case management. Such a centre could coordinate innovative, high-quality research, and foster collaborations between universities, governments, businesses and unions. The Health Research Council of Aotearoa New Zealand could also provide leadership in this field, as it has done in the field of health housing.[192]

The field would also benefit from greater stakeholder engagement to inform and drive research and share positive approaches. More discussions, meetings and other forums would be beneficial in this regard.[193]

Independent medical examinations (IMEs)

Perceived fairness

Practitioners new to IMEs are likely to benefit from training. IMEs are outside normal practice for many medical practitioners. Practitioners may not be aware of the impact of an IME on workers' perceptions of fairness, but feelings of injustice are common when workers do not feel they have been heard or understood.

Encounters with IME practitioners are expected to be less stressful if pre-appointment information is comprehensive. It would also be beneficial if IME practitioners received training in the principles of procedural justice and applied these to their role. Training IME practitioners in the delicate task of writing reports based on their clinical opinion and expressed in a way that does not disenfranchise the worker may also assist.

Some referrers require practitioners to be in active clinical practice. Research is yet to establish whether this improves the quality of IME consultations and reports.

The purpose of the IME

At times, IMEs are needed for legislated requirements (e.g. assessment of permanent impairment). At other times, the assessment may be arranged to influence the treating practitioner.

Alternative arrangements are available in some jurisdictions, including second opinion services that the treating practitioner can arrange, with advice received directly. In NSW, an independent medical consultation is specifically designed to incorporate discussions with the treating practitioners. In Victoria, an IME practitioner may be asked to see the worker and visit the worksite to explore work options as a way of influencing the treating practitioner.

Clarity of purpose will help shape the arrangements. If a traditional IME is undertaken, the process should be clear. Sharing of IME reports with the treating practitioner should be standard.

Use of the same IME practitioner is recommended if a repeat IME is needed. There are many reasons for this, including that the practitioner is in a better position to assess health and RTW issues if seeing the patient over time. The worker does not need to repeat their history multiple times, and seeing the same practitioner is generally less stressful. 'Doctor shopping' to obtain a desired opinion is an inappropriate claims management strategy[23] and should be avoided.

IMEs can be more stressful for those with mental health claims. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommends treating clinicians be consulted in preparation for a genuinely needed IME to ensure that patients are prepared and supported as much as possible.[194,195]

Enhancing the use of occupational epidemiology

Research on contributing factors to musculoskeletal conditions is of variable quality, can be difficult to access and requires considerable time to evaluate. For example, many research studies evaluate people at one point in time (cross-sectional study), which is open to recall bias. Other studies are on limited numbers of people, and such studies may not objectively evaluate the work demands. Disagreements about work contribution understandably follow from lack of a shared understanding of up to date currently available research.

The establishment of an agreed central pool of higher quality research may help develop a shared and improved understanding of the nature of work risks and their contribution to common musculoskeletal conditions such as back pain, shoulder conditions, carpal tunnel syndrome etc. In turn, this would help to reduce unnecessary disputes.

Key elements for better outcomes

Develop and communicate a clear model for insurance case management

⇒ Clarify the principles of best practice case management, including the principles of service delivery and administration. Important principles of service delivery include early risk identification, adopting a person-centred approach, prompt decision-making and procedural justice, collaboration, empowering the worker and the workplace to secure timely RTW, being just, and recognising the education, skills, knowledge, competencies and experience needed to be effective.

⇒ Consider the development of a set of national principles of practice for insurance case managers, informed by the biopsychosocial model of health and recovery. The *Principles of Practice for Workplace Rehabilitation Providers* could act as a template.

Improve the case management operating environment

⇒ Include a systematic approach to risk identification and the needs of workers, providing extra support to those more likely to have prolonged work absence.

⇒ Where possible, ensure consistency of case managers over the course of the claim.

⇒ Invest in early intervention approaches through appropriate caseloads, early engagement of the worker and the workplace, and extra support for the worker where appropriate.

⇒ Set up systems that enable timely decisions about claims determinations, wage replacement payments and treatment to reduce frustrations experienced by workers and their treating healthcare providers, distress, and the development of prolonged work absence.

⇒ Minimise paperwork and other bureaucratic demands for case managers and other scheme participants to allow more time for case managers and other scheme participants to focus on recovery and RTW.

⇒ Streamline and simplify communication through friendly formats, with letters written in language that is easily understood, taking into account the fact that some workers have low literacy or are unfamiliar with English.

⇒ Develop the competencies and skills of case managers and resources that support RTW. Avoid the perverse incentives that can arise through short-term targets via KPIs.

⇒ Use case management software that is user friendly, supports case management activities and minimises the need to move between varying software systems.

Develop the case management industry

⇒ Invest in the long-term development of the case management workforce through better selection, training, retention and career development pathways.

⇒ Select insurance case managers for their people skills, including communication skills and capacity to influence others, service coordination and collaboration abilities, and empathy.

⇒ Improve the training of case managers in RTW skills and the technical components of case management within their jurisdictions.

⇒ Develop national standards for the training of prospective case managers and include training requirements in the selection criteria.

⇒ Recognise and address the emotional demands of case management. Support case managers via coaching on how to deal with difficult people, mentoring, facilitating early requests for support, and regular surveys of case manager morale and needs.

⇒ Implement a system for mentorship, transfer of knowledge, support and connection.

⇒ Ensure case manager turnover is low through retention strategies: attractive pay and conditions, appropriate caseloads, career pathways, an ability to work in line with the values of fairness, trust, respectful communication and empowerment of stakeholders.

⇒ Reduce the bureaucratic load to ensure case managers can focus on the worker and the workplace and RTW.

⇒ Reduce disputes where possible through procedural fairness and good decision-making. Make communication personal, complete actions within agreed timeframes, explain the process, ensure the person has a chance to have input into the process, deal with the person with respect, and communicate the result of decisions in a timely and respectful manner.

Address the social determinants of health

⇒ Recognise that some groups such as Māori, Aboriginal and Torres Strait Islander peoples and people from non-English-speaking backgrounds need to have equitable access to services and culturally safe and appropriate case management.

⇒ Ensure organisations commit to programs that appropriately respond to the need for programs for Māori in Aotearoa New Zealand and others who should have access to culturally appropriate care and co-designed initiatives. Further, develop and support the Māori case management workforce and Māori leadership.

Improve IME processes

⇒ Recognise IMEs and other investigations can be stressful for workers. Ensure letters about IME appointments are simple and easy to understand and explain their purpose.

⇒ Educate IME practitioners about the negative health and recovery impacts of perceived injustice and employ strategies for conducting IME consultations and writing IME reports that promote perceptions of fairness amongst injured workers.

⇒ Where possible, use the same IME practitioner for repeat consultations. This enables the clinician to assess changes over time and is less stressful for the worker.

⇒ Where there is an agreed history of the injury, share that with the IME practitioner so the worker does not need to repeat the same history on multiple occasions. This is particularly the case for people who have experienced significant trauma.

⇒ If the worker is to undergo a psychiatric IME, involve their treater to provide support prior to the IME consultation.

⇒ Routinely share IME reports with treating practitioners, for transparency, accuracy and accountability, and coordination.

Develop case management through a coordinated research agenda

⇒ Develop a long-term research agenda. Consider the establishment of a research institute focused on case management to facilitate research, discussions, meetings and forums necessary to identify effective case management approaches. Options include NHMRC Partnership Projects, NHMRC Centres of Research Excellence, ARC Industry Linkage Projects and Cooperative Research Centres in Australia, and the ACC in Aotearoa New Zealand.

⇒ Compare and evaluate the experience and capabilities of case managers across Australian and Aotearoa New Zealand to gain an understanding of their training and development and support needs.

⇒ Develop a shared understanding of which case management strategies are effective – that is, promote recovery and RTW – and which create barriers.

⇒ Evaluate structures for case management teams, such as the ratio between case managers to injury management advisers. Assess whether case management teams are best aligned with case duration, the nature of the industry, case complexity or some other factor.