

Clinical Framework for the ACC Sensitive Claims Unit

June 2009





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Clinical Framework for the ACC Sensitive Claims Unit – June 2009

The information presented in this *Clinical Framework* is a guide to managing treatment requests for clients who lodge sensitive claims with the ACC Sensitive Claims Unit. This Framework should be read in conjunction with information on Informe - ACC's online policy and procedural manual for the management of claims.

The Clinical Framework reflects the most current approach to the treatment of injured clients, demonstrating recent developments in evidence based practice and points to the future use of objective outcome measurement by treatment providers. The success of the Clinical Framework will be seen with improved health, a return to normal function and a return to work outcome for our clients.

Purpose of treatment

ACC's responsibility is to increase the injured clients' capacity to function to as close to their pre-injury level as practicable.

The purpose of providing treatment is to restore the injured clients' health to the "maximum extent practicable". To achieve this ACC has adopted a rehabilitation philosophy to assist injured clients, with the goal of achieving an appropriate quality of life. We do this through the provision of ACC-funded supports that help the client achieve health and reduced dependence on ACC.

The ACC Sensitive Claims Unit (SCU) will utilise ACC tools and processes such as the Service Delivery Model¹ and the Health Purchasing Framework² to manage these claims based on the context of the injury, such as the age of the client when they were injured.

ACC is committed to using evidence-based decision-making for treatment and health care, based on sound evidence of clinical effectiveness. Evidence-based decisions take into account the effective use of resources.

The Clinical Framework outlines a set of guiding principles that form a consistent policy framework for the delivery of health services. The Clinical Framework reflects the most contemporary approach to the treatment of injured clients, demonstrating recent developments in evidence-based practice and use of objective outcome measurement in clinical practice.

Purpose of the Framework

SCU staff have accountabilities to ACC and our clients to manage claims effectively. To realise these accountabilities SCU staff will be supported to develop their capabilities and to work in teams with a mix of knowledge and skills that can be applied to decisions on claims.

1. <http://acctoday/projects/service-delivery-model/index.htm?ref=ournews>

2. <http://acctoday/projects/health-purchasing-and-provider-relationship-programme/PRD.CTRB108354>

This Clinical Framework has been established to provide a set of guiding principles for the provision of treatment services (and other entitlements) for clients, health professionals, treatment providers and ACC staff.

Through this framework ACC will focus on:

1. Ensuring services are goal oriented, evidence based, clinically justified and use resources effectively.
2. Optimal rehabilitation outcomes including a return to normal functioning and return to work.
3. Informing providers of ACC's expectations for the management of injured clients and the outcomes required.

With regard to counselling for sexual abuse the objective for this form of treatment is noted in the document *Information for ACC Registered Counsellors*³. Counselling is used to “facilitate rehabilitation for clients using processes and practices that have been researched and demonstrated to be effective”.

To support this ACC commissioned the School of Psychology at Massey University to develop evidence-based practices guidelines. These ‘Massey Guidelines’ were published in 2008 and are available on the ACC website.⁴

This Clinical Framework draws on the Massey Guidelines and the rehabilitation approach that underpins ACC activities to provide guidance for ACC staff, clients and treatment providers. The information in the Massey Guidelines and this Framework will be used to inform clinical pathways for injured clients.

Principles

The Clinical Framework contains a set of principles for decisions about services for injured clients:

- Principle 1:** We support the rehabilitation of injured clients
- Principle 2:** Treatment must focus on empowering the client to manage their injury
- Principle 3:** Measurable treatment effectiveness must be demonstrated
- Principle 4:** Goal setting is a means of improving function and return to work
- Principle 5:** Treatment must be based on the best evidence available
- Principle 6:** Decisions about claims are made within the bounds of legislation
- Principle 7:** We share responsibilities for injured clients with the wider community
- Principle 8:** We will develop the capabilities of staff members to support the rehabilitation of injured clients
- Principle 9:** We will use all the available expertise in making decisions

3. ACC Sensitive Claims Unit, August 2007. As noted in the ACC Strategic Plan available from <http://www.acc.co.nz/publications/index.htm?ssBrowseSubCategory=Reports%20and%20strategy>

4. Sexual Abuse and mental injury: Practice Guidelines for Aotearoa New Zealand. ACC March 2008

Requirements

Decisions about services for injured clients will follow the principles of the Clinical Framework and the Clinical Pathways developed for use in the SCU.

ACC staff will promote the following key messages to clients and providers.

Key messages

1. The goal of rehabilitation is to restore the function of those who are injured.
2. Effective decisions on rehabilitation and treatment take account of resources.
3. ACC's accountabilities and responsibilities relate only to conditions caused by injury.
4. Interventions are funded according to evidence and shaped to manage the risks presented by the client.
5. Clients with pre-existing injuries or other health issues will be managed in collaboration with other agencies.
6. Counselling has a focus on empowering the client to manage their injury.
7. A good therapeutic alliance is a means of improving function. Goal setting, collaboration and a good therapeutic relationship are its three key elements.
8. The effectiveness of counselling or other treatments should be demonstrated using outcome measures. An outcome is a change in the status of a client as a result of an intervention.
9. When available, the outcome measures used should be:
 - a. reliable, valid and responsive to change
 - b. related to rehabilitation goals
 - c. relevant to the client's injury
 - d. needed by ACC to make decisions about claims.
10. Regular use of outcome measures provides a justification for treatment decisions that can include continuing, changing or ceasing treatment or referring the client to another provider.

ACC has a skilled team to manage sensitive claims. We will develop the capability of this team and match the skills of team members to the rehabilitation needs of clients.

Principle 1: We support the rehabilitation of injured clients.

The best method of maximising recovery is through implementation of the rehabilitation model. This includes early identification of barriers to recovery and factors that require specialised assessment or treatment. From the time a claim is received support and treatment of the injured client will include assessment of the multiple factors that can impact on recovery and return to work, such as:

- biological factors
- co-morbidity
- psychological factors such as illness beliefs and beliefs about return to work
- social factors
- work demands.

When a client is not recovering as expected it is the responsibility of treatment providers to advise on an alternate treatment plan. While the prime role of ACC is to manage the covered injury we will consider all factors that inhibit rehabilitation. We may work with a range of agencies and providers to address those barriers.

Overcoming barriers to improved function and return to work

To ensure barriers are overcome in the shortest timeframe there are several questions we should ask ourselves and the client:

- Which barriers are preventing the client/worker from returning to function and work today?
- Has an up-to-date rehabilitation plan been developed and implemented?
- Is the treatment being provided having the expected effect on the client's function?
- Would another form of intervention improve the client's rate of recovery?

Principle 2: Treatment must focus on empowering the client to manage their injury

As part of rehabilitation SCU staff will encourage the client (and their supporters if appropriate) to take steps to manage their recovery from injury. This may include an individual rehabilitation plan as well as:

- management of medications
- educational or counselling support
- rehabilitation aids or services to maintain activities of daily living and work
- information on the roles of treatment or assessment providers in the recovery process, the injury and expected recovery times
- information on alternative activities that will support recovery.

One measure of treatment effectiveness is the ability of the client to independently manage their injury. By following the principle of empowerment, SCU staff and providers will support clients to become independent of health providers. This does not mean every client will be free of symptoms, but rather most clients will achieve a productive life while self managing any symptoms that arise. As with physical injuries the failure to empower a client can result in dependency on passive treatment, which reinforces illness behaviours.

To avoid this situation we may recommend a gradual reduction in the frequency of treatments over a defined period of time (in consultation with the client and their treatment provider).

Principle 3: Measurable treatment effectiveness must be demonstrated

Functional outcome measures

Functional outcome measures assess the client's ability to perform usual daily activities including work tasks and other roles. Specific and measurable information should be reported, for example an improvement in functional outcome may be an improvement from 10 hours per week at work to 25 hours per week without restrictions, or increased self management of symptoms enabling greater participation in routine activities e.g. attending appointments and training.

Customised outcome measures

If no validated outcome measures are relevant to the treatment goals of a client, the health provider should use customised outcome measures that are directly related to the treatment goals. The document *Information for ACC Registered Counsellors* provides comprehensive guidance on goal setting and measures of outcome (pages 13 to 15 and beyond), including the need for SMART goals in counselling practice.

The provision of regular progress reports is a way to track outcomes and assess the effectiveness of treatment. This also assists SCU staff to develop and modify individual rehabilitation plans, including:

- requests for additional counselling
- planning the duration of counselling
- considering additional or alternative treatments
- reviewing the completion of counselling.

Principle 4: Goal setting is a means of improving function and return to work

Goal setting is an important part of achieving any objective and is particularly relevant for injured clients. Goals focusing on return to function and return to work should be developed in collaboration with the client at the beginning of the assessment and treatment programme. Goals need to focus on measurable improvement in activity in order to allow an evaluation of progress.

Goals should be specific, measurable, achievable, relevant and time bound – SMART goals.

Goal setting, including Individual Rehabilitation Plans needs to take account of the context of the injury, environmental factors, and pre-existing illness or co-morbidities.

Treatment goals should be periodically reviewed and upgraded as the client progresses, or modified if circumstances change or if significant barriers are identified.

When functional improvement is slow or absent, resetting expectations regarding recovery is required and if necessary a referral to an appropriate healthcare provider to manage conditions that ACC does not cover.

Principle 5: Treatment must be based on the best evidence available

Extensive research literature exists on the efficacy of different treatment modalities and clinical decision making must therefore be directed by this evidence.

Evidence-based practice allows providers to optimise a client's function and return to work outcomes by:

- offering treatment that has the best chance of success
- avoiding treatment that is likely to be ineffective
- avoiding therapy that is wasteful of time and resources.

In accordance with evidence-based principles, health professionals and treatment providers need to integrate the “*best research evidence with clinical expertise and patient values*” (Sackett et al, 2000).

Treatment providers/counsellors are expected to take responsibility for maintaining their own competence and demonstrating this.

Where is the best evidence available?

With regard to counselling for sexual abuse, ACC commissioned the School of Psychology at Massey University to develop evidence-based practices guidelines. These ‘Massey Guidelines’ were published in 2008 and are available on the ACC website.⁵

The information in this guideline will be used to inform clinical pathways for injured clients. The Massey Guidelines represent the current best practice for counselling. ACC staff and providers will be required to adhere to the recommendations. Exceptions and variances will need to be clearly identified and justified.

5. Sexual Abuse and mental injury: Practice Guidelines for Aotearoa New Zealand. ACC March 2008

Principle 6: Decisions about claims are made within the bounds of legislation

While ACC strives to restore a client's health, participation and independence, to the level that the client has lost as a result of the injury, ACC does not have a mandate to go beyond that level.

Decisions on cover and treatment for mental injuries will be made at appropriate times when there is information available to the SCU staff.

Clause 2 of Schedule 1 of the IPRC Act sets out the criteria to use when deciding whether to pay for an instance of treatment. When considering any type of treatment, SCU staff should consult with clinical colleagues (including the psychology advisor, medical advisor), with the Support Co-ordinator or Team Manager, or with the Technical Claims Manager about approving or declining the request.

Principle 7: We share responsibilities for injured clients with the wider community

While ACC assesses and manages claims for injury this does not mean that we have sole responsibility for clients with an injury. Most clients with sensitive claims will have other social, health, educational or other issues that impact on rehabilitation. Some will have emotional, behavioural or cognitive problems that pre-date the injury.

ACC needs to be clear which issues are the primary responsibility of ACC and which are the responsibility of other agencies or providers e.g. clients with the most severe mental injuries are best managed by DHBs. Agreements are in place for this situation.

To ensure that injured clients return to health and independence we will work co-operatively with the client, their family and supporters, their therapy providers, and with other agencies to ensure the supports funded by ACC match the client's covered injury. We will co-ordinate our activities with others to ensure that non-injury needs are taken account of by all those providing support to injured clients.

Principle 8: We will develop the capabilities of staff members to support the rehabilitation of injured clients

Staff in SCU have a range of knowledge and skills that support injured clients. We will provide learning and development opportunities to all staff so they can better assist injured clients.

The structure and processes of the SCU will evolve to ensure the risks presented by clients are managed effectively by teams with the right capabilities.

The SCU will prioritise requests and claims management tasks to ensure those issues that present the greatest risks are managed effectively. This will include review of most decisions by multi-disciplinary teams and / or team managers. We will support this by monitoring our achievements with feedback to teams and staff members.

Principle 9: We will use all the available expertise in making decisions

The SCU has case management, clinical and technical expertise supported by team leaders and administrative staff.

The SCU will develop processes to ensure all decisions on claims and all requests are considered by staff members with the right level of knowledge, skills and experience. This will include processes to correctly escalate issues to clinical experts, technical experts, team managers or panels of experts for further consideration.

Methods of consultation may include:

- formal and informal discussions one-to-one
- peer review meetings and Panel discussions
- written requests for advice.

Prior to consultation the SCU staff will assess the request against the established criteria, including Clinical Pathways developed for use in the SCU.

Clinical Pathways

In keeping with other health and disability sector agencies, ACC is adopting a **Clinical Governance** framework to provide guidance for clinical staff employed by ACC.

Clinical Governance is a system to establish standards of care, accountability for those standards, and support continuous review or improvements.⁶ Rapid changes in knowledge about health care over the last decade are expected to continue in the future, so a key part of any clinical governance framework is a system to manage the evolving scientific evidence base about treatments.

Within the SCU, **Clinical Framework** and **Clinical Pathways** provide a similar function in guiding people who make decisions about treatments or the use of resources for clients with a sensitive claim.

The **Clinical Framework** describes the basis for managing treatment requests for clients who lodge sensitive claims with the Sensitive Claims Unit. The Framework includes an overall purpose and a set of principles to guide decisions on claims including decisions of treatment.

Clinical practice guidelines, clinical pathways, referral guidelines, clinical summaries and best practice protocols are all established methods for providing relevant, up-to-date information “to guide decisions about appropriate health and social care to improve individual and population health and wellbeing”.⁷

Clinical Pathways (Care Pathways, Integrated Care Pathways, Care Maps) have been developed as tools to maintain the quality in health care by standardising care and decision-making processes. They have been shown to reduce the variability through the use of evidence based practices, and thereby improve outcomes. Clinical Pathways can be applied to a range of settings, practices and disciplines including situations where multiple disciplines are involved in providing care. Within the context of the SCU we will develop Pathways that provide guidance on the interventions and tasks to be undertaken by treatment or assessment providers, and others involved in the care of our clients.

Within the Pathways, best practices will be identified for the predicted clinical course based on injury duration and type, client demographics, and other relevant factors. Pathways will also define or describe the relevant tasks and outcome measures.

6. Clinical governance is the term used to describe a systematic approach to maintaining and improving the quality of patient care within a health system.

7. Within New Zealand the Guidelines Group (<http://www.nzgg.org.nz/>) is the recognised as the leader in producing high-quality, systematically developed, independent information for healthcare decision-making. The New Zealand Guidelines Group has a collaborative network of clinicians and consumers to develop evidence-based guidelines and also has links to the international Cochrane Collaboration and the Guidelines International Network. The Massey Guidelines were developed by use of a process comparable to that used by the NZGG.

The Pathway for Sensitive Claims

The generic pathway is a stepwise one with the following elements:

1. Assessment for cover
2. Therapy includes:
 - the client's Individual Rehabilitation Plan
 - usual care
 - variations and exceptions
 - cost
 - expected treatment
 - additional assessments
3. Completion i.e. recovery.

Decisions on cover and treatment for mental injuries will be made at appropriate times when there is information available to the SCU staff.

When considering any request, SCU staff should consult with colleagues (including Clinical Advisors, Support Co-ordinators, Team Managers, or the Technical Claims Manager) about approving or declining the request.

Methods of consultation may include:

- formal and informal discussions one-to-one
- peer review meetings and panel discussions
- written requests for advice.

Prior to consultation, the SCU staff will assess the request against the established criteria, which can be thought of as a series of questions. These questions are derived from our legislation, the Clinical Framework, the Massey Guidelines and the Clinical Pathways we develop.

For example:

- Does the client have cover for the personal injury?
- Is the need for this treatment related to the level of functioning that has been lost as a result of the covered mental or physical injury?
- Will the treatment contribute to restoring the client's mental or physical health to the maximum extent practicable, but not enhance it beyond the pre-injury level?
- Is the treatment necessary, and appropriate? Will the treatment be of the quality required to contribute to restoring the client's health?
- Is the frequency of providing the treatment enough (and only enough) to contribute to restoring the client's health?
- Are the time and place of the treatment appropriate?

- Is this a type of treatment that a treatment provider normally provides?
- Is the treatment provider qualified in providing this type of treatment?
- Does the treatment require prior approval?

Other decision-making considerations

In deciding whether these criteria have been met, always take these factors into account:

- The nature and severity of the injury
- The generally accepted means of treatment for such an injury in NZ
- The likely benefit of the treatment to the client.

Counselling as part of treatment

Counselling has been used extensively as an intervention for clients with a covered sensitive claim. While the Clinical Pathways will provide guidance on the use of counselling applicable to most claims, there may be exceptional circumstances which will affect the duration, intensity and type of counselling needed in some cases. Factors which may alter the amount or extent of counselling or other treatments are noted below.

Relevant issues to be addressed in determining appropriate treatment include the following:

- continuous sexual abuse during childhood
- an assailant known to the victim and trusted by them for example a parent, relative, or professional person (doctor, teacher, therapist, etc).
- a life-threatening sexual assault
- lengthy sexual assault with no 'escape' from their situation
- severe sexual violence
- repeated sexual assaults over time
- sexual assault that is undisclosed for over 12 months
- sexual assault in a client's home, workplace or other 'safe' setting.

Or when the injury occurs and:

- the client blames themselves
- the client has a history of being in a dysfunctional family
- the client has a history of psychological problems
- has a social or family network that is not supportive
- the sexual assault occurs within a year of other traumatic life events

- the client suffers from further trauma as a result of processes in the justice or health system
- there is further boundary violation subsequent to the event
- the perpetrator is found 'not guilty'
- the context of the injury points to a greater severity of injury or risks for the client.

Note: The clinical expertise required to undertake treatment of some injuries or conditions may require supervision by a clinical psychologist. These matters will be considered in development of clinical pathways by the SCU.





Te Kaporeihana Āwhina Hunga Whara

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