

Occupational Health Physiotherapy Group



Submission to Independent Review of Physiotherapy / ACC Relationship

Key Issues

- Physiotherapists delivering ACC services under the vocational rehabilitation contracts do not receive the same or similar funding benefits or opportunities compared to other physiotherapists delivering ACC services under the medical fees model. This is despite additional costs borne by some occupational health physiotherapists in achieving accreditation, as they may be working in a multi-disciplinary model, which requires much more work to achieve accreditation, or in a non-clinic environment. All physiotherapists delivering vocational rehabilitation services to ACC must do so under national contracts. Many of these contracts have gaps in the funding of services required to deliver safe and effective physiotherapy for injured workers, and are inadequately funded.
- National contracts require physiotherapists to fund at the end of the service which could be up to 12 weeks, and delays and errors in processing invoices could add an additional 12-20 weeks for payments. This creates significant increases in administrative work to track and store costs prior to invoicing and extreme delays in cash flow for the provider, who is still required to pay their personnel and business running costs on a weekly basis until the payment is received. This contrasts greatly with most other fee payment models within ACC
- There is inequity within the funding levels of the national ACC contracts, resulting in physiotherapists receiving variable and often inadequate funding to provide similar or same service under the different contracts.
- The OHPG and NZSP have been bringing this to the attention of ACC since 1998 but little has been done to acknowledge or address these issues. It is now at the point where delivery of vocational rehabilitation services to ACC clients is in jeopardy, and the safety of the ACC client, employer, and health service provider are all at risk. This needs addressing urgently.

Background History

The Occupational Health Physiotherapy Group Inc.(OHPG) is a special interest group of the New Zealand Society of Physiotherapists Inc (NZSP), and has a membership of approximately 170. Occupational health physiotherapy is a relatively new area for physiotherapy, having developed over the last 15 years.

Key differences include:

- The service is usually delivered in the workplace, out of the traditional physiotherapy clinic setting.
- The issues for injured workers are often complex and “work rehabilitation” is now accepted as a specialised area to work in for the multi-disciplinary team of health professionals involved. These may include the physiotherapist, occupational therapist, GP, occupational health physician, clinical psychologist and vocational/careers adviser.
- Physiotherapists working in this area are obliged to work under multiple legislations, including the Health Practitioners Competency Assurance Act, Health and Safety in Employment Act, Employment Relations Act, as well as the Injury Prevention Rehabilitation and Compensation Act.
- As well as the traditional core competency physiotherapy skills, occupational health physiotherapists are also required to deliver a wide range of related services and demonstrate competency in the following:
 - injury prevention
 - safe manual handling and other work practices
 - have a basic understanding of ergonomics
 - work organisational factors
 - wellness programmes

- functional capacity evaluations
- workstation assessment and design
- task analysis and modification
- development and monitoring of return to work programmes
- assisting to identify and resolve employer/employee issues
- assessment and management of psychosocial issues

and work with a large multi-disciplinary team including:

- employee
- employer
- family/whanau
- union representative
- supervisor or manager
- health and safety representative
- human resources representative.

Contracts commonly worked under the following:

Graduated Return to Work

Consists of different components including:

1) Work Place Assessment

This full assessment is for ACC clients, usually takes place in the workplace, and is performed where there are one or multiple tasks and/or workstations within the job. The assessment looks at the following:

- Background history of injury, ongoing symptoms, limitations and abilities.
- Underlying or relevant medical conditions.
- The normal work tasks and job demands.
- The range of tools and equipment that would be used in the job.
- The environment in which the job tasks are performed.
- Psychosocial factors influencing return to work
- The availability of selected or alternative duties if required.
- Special needs of the job, e.g. personal protective equipment.
- Modifications to equipment, tasks, hours or environment that may assist in returning or maintaining the injured employee to/at work.
- Should also include an outline of a return to work plan, to assist in returning the injured worker back to full pre-injury work hours and tasks.

2) Graduated Return to Work Programme

This ACC programme outlines and oversees a return to work plan for an injured worker, and will include:

- The range of tasks that is available and the progressions back to pre-injury tasks.
- The graduation of hours and/or days to return the injured worker to full-time hours.
- Suitable tasks with gradual progressions back to full tasks.
- Special requirements or restrictions to initially protect the worker from incurring harm.
- Supervision and monitoring requirements to ensure that the worker is coping with the return to work programme. Monitoring is usually face-to-face but may be by phone, email or fax depending on the circumstances of the programme.
- Monitoring occurs on a minimum fortnightly basis but is often weekly to review progress and to adjust the programme accordingly.

3) Work Place Review

A workplace review is an ACC funded service and used for a range of situations such as re-evaluating an employee's work ability, status, developing a RTW plan, evaluating and organising equipment needs (is presently under review).

4) Return to Work Plan

This plan outlines a framework for returning an injured or ill worker back to work, preferably to their pre-injury level. It may include:

- The range of tasks that is available and the progressions back to pre-injury tasks.
- The graduation of hours and/or days to return the injured worker to full-time hours.
- Suitable tasks with gradual progressions back to full tasks.
- Special requirements or restrictions to initially protect the worker from incurring harm.
- Supervision and monitoring requirements to ensure that the worker is coping with the return to work programme.

It may be done separately, at a later timeframe from the original workplace assessment or worksite visit, if it was too early to clearly define the plan at the first assessment.

Gradual Process Task Analysis for Cover Decision

This is an assessment that is undertaken when a worker has reported gradual discomfort occurring in the workplace which is not related to a specific incident. This assessment assists the insurer or employer to determine task demands and claim liability. The assessment usually consists of:

- Presenting history and symptoms.
- Present management to date.
- Other relevant factors such as hobbies, non-work related causes, underlying medical conditions.
- Detailed list of the work tasks and job demands, e.g. forces, awkward or sustained postures, repetitions, environment factors, exposure to chemicals and toxins tool use, etc.
- Objective findings on that day.
- Possible differential diagnosis.
- Relationship of symptoms and tasks to evidence-based conditions.
- Further recommendations for management.

Work Ready Workplace Assessment

This assessment is done for a person commencing a work trial, to demonstrate or allow gradual build-up of tolerance for a particular job. This assessment will include:

- A brief overview of the person's condition and present abilities and limitations.
- Overview of the work trial plan, including hours, tasks, and job demands.
- Outline of a graduated plan to full-time hours if required.
- Any special equipment or environmental modifications.
- Reporting and monitoring requirements.

The work trials will usually occur from three to eight weeks, but may extend to twelve weeks at times.

Functional Capacity Evaluation

A functional capacity evaluation is an assessment to determine a person's functional abilities, strengths, skills and capacity to perform tasks related to employment or other activities. It is often used as a guide to assist in determining relevant work options. The assessment will include:

- Current functional abilities and limitations.
- The safe levels of working function, including ability for part-time or full-time work, need for graduated hours in a return to work programme.
- Identification of barriers to further rehabilitation, including anxiety, depression, activity fear, etc.
- Identify any equipment, aids or appliances that may assist the person to return to the workplace.
- Identify barriers which are non-injury related, e.g. medical.

This assessment will usually take a minimum of two hours to perform. A complex FCE may be required if there are multiple problems to be assessed.

Task Specific Functional Capacity Evaluation

This is used by insurers or employers when an employee is not coping with their full job demands and assesses the barriers to performing their specific tasks. It includes:

- Gathering the history around the reported injury or discomfort
- Brief objective assessment
- Overview of job tasks and demands
- Observation of employee performing specific work tasks. May include heart rate monitoring, exertion scales and pain rating levels.

Report will include recommendations for ability to perform job safely, health management strategies, and employer strategies to ensure employee is safe at work.

It can also be requested by insurers for assessment of ability to undertake home based activities. This identifies home help needs and other rehabilitation strategies such as strengthening or fitness programmes, or training in manual handling techniques that could improve functional ability.

Employment Maintenance Programme

This is a programme designed to maintain activity and work routine once an ACC client is cleared for light or selected duties but there are none available to return to.

Issues of Concern

The following issues show that there are a range of problems identified by providers with the way ACC contracts physiotherapists to work on occupational health contracts. Together these issues mean that delivery of service of patients relies in many cases not on a robust contracting of services by ACC, but upon the good will of physiotherapists and their commitment to patient welfare overcoming major gaps in funding.

Inadequate and inequitable travel rates within the ACC national contracts

1. There are gross differences in funding of travel by ACC for health professionals delivering services under national contracts. Funding is required both for travel expenses like petrol and vehicle use, and for the physiotherapist's travel time.
2. Currently the rates vary from contract to contract and are determined in different ways, e.g. percentage of an hourly rate, kilometres travelled, time travelled, with rates for these varying. The method described by ACC to calculate travel for multiple clients seen over a region is also vague and unfair. This makes it extremely difficult when undertaking the administrative functions associated with invoicing.
3. There was no increase in travel cost reimbursement since the introduction of the national contracts in 1998 until late 2006, yet petrol costs have gone up over 80% in that time.
4. Until a few months ago therapists could not claim for travel less than 40km round trip for a client, yet some therapists in the larger metropolitan areas could clock up hundreds of kilometres in one day, yet be technically unable to claim for either the time or distance travelled.. This is a direct cost to deliver the service and should be funded appropriately.

Proposed Solution:

ACC now funds 20km round trip for most contracts-this should be across the board for all contracts. All travel rates should be standardised and should be at a reasonable rate that reflects true costs to cover travel (time and distance).

A clearer and fairer way to calculate and apportion travel costs should be devised by ACC.

Failure to Fund Equipment Related Time of Physiotherapists

5. The ordering, management and liaison of equipment under the Vocational Rehabilitation contracts has been omitted since the contract started in 1998. Therapists initially worked around this by negotiating with the case managers at a Branch level to invoice them on a private rate. This is no longer possible since the purchase order number system was introduced earlier in 2006. This has meant that therapists have been required to deliver this service for free, with the inability to charge ACC for the time and effort required to administer this part of the contract.

6. If the service is not provided then it jeopardises the safety of the ACC client in the workplace and would put the therapist in breach of professional practice standards and registering body standards, creating further dilemma for the therapist. ACC has been very dismissive of the concerns repeatedly raised around this issue, and has only very recently acknowledged there is a gap and has stated it will look at addressing this issue.

Proposed Solution:

ACC to work with providers to resolve this issue and fund appropriately for the equipment management and liaison associated with Vocational Rehabilitation contracts.

“Did Not Arrive” Patients

7. Inability to charge for clients failing to attend for appointments. The “did not arrive” (DNA) component has been an issue for therapists working under the national contracts. Some of the contracts (Activity Based programmes, Gradual Process Cover workplace assessments, EMP) omitted to fund for non-arrivals by clients.
8. Assessments for most contracts usually take at least an hour, and other clients cannot suddenly be fitted in to cover this gap., room hire is required and travel is usually required, yet there has been until recently no ability to fund for this either. Again, ACC has repeatedly ignored NZSP’s concerns about this.

Proposed Solution:

ACC to work with providers to resolve this issue and appropriately fund the providers for missed appointments and direct costs associated with clients failing to attend for appointments.

Level of Remuneration

9. Adequate reimbursement for services provided – general. Again, there have been irregularities and anomalies between funding for the national contracts. For example, initially the social rehabilitation contract was costed at \$60 per hour, the FCE at \$80 per hour, the EPN at \$90 per hour, the hand therapist at a slightly higher rate, services not covered under the national contract at the individual provider’s rate, the Employment Maintenance Programme (EMP) at approx \$40 per session (or approximately \$90 per hour). This means that the same physiotherapist could be paid varying amounts when using the same physiotherapy skills and competencies. The private market rate is approximately \$100-\$120.00 per hour.
10. Disparity within the EMP contract has a psychologist earning \$120 an hour, yet the physiotherapist only earning \$90 an hour. However, both require similar lengths of training. We believe that the skills of a physiotherapist are equivalent to those of the psychologist, and we should have pay parity as a minimum.
11. There is no recognition for post-graduate skills or if the contract holder has attained accreditation, unlike the EPN contract.
12. Compliance costs to work and deliver the ACC vocational contracts have gone up significantly since the introduction in 1998, yet the fees only went up for the first time in 2005, by 4%. It was estimated by the occupational health physiotherapists that in 1998, to meet quality compliance with the vocational rehabilitation contract, that therapists working 51 hours per week would spend 19 of those hours in unpaid work to meet compliance. This would include:
 - continuing education
 - post-grad education
 - quality assurance work
 - customer surveys
 - collection of client statistics for contract KPIs, and reporting and collating these for quarterly reports back to ACC
 - self-directed learning to maintain competency
 - attendance at conferences, seminars and meetings, to maintain competency (this does not cover the normal service delivery management, e.g. booking of appointments, following up of DNAs, invoicing, archiving of files, writing and sending of report to all parties).

Proposed Solution:

ACC to fund providers appropriately at a rate which reflects their market worth, and covers the real costs of meeting the high quality ACC requires for contract delivery.

Liaison Costs

13. Presently there is a gap in the vocational rehabilitation contracts as the contract fails to state how the reports generated on the ACC client will be shared amongst all stakeholders in a timely manner, and by whom. Nearly all occupational health physiotherapists have had to undertake this task themselves for no reimbursement. We believe that the safest way of timely delivery of these reports to the whole multidisciplinary team is to specify that each stakeholder should distribute their report amongst all others. However, this must be remunerated.
14. Further, there is no cover required within the vocational rehabilitation contract for broader liaison within the multi-disciplinary team, yet evidence-based research clearly supports the need for a multi-disciplinary approach in work rehabilitation, especially when it goes over the expected timeframes. This is having to be absorbed into a standard weekly fee (the therapist gets paid whether they spend one hour or six hours of that week on that client), is done at the therapist's own cost, or is not being undertaken, to the detriment of the patient.
15. It should be noted that as the number of stakeholders involved in rehabilitating a client back to work is much greater than for a management of a simple medical client, there is therefore much significant work required to share and transfer information between all relevant stakeholders. This is to ensure the safety of the ACC client, employer and provider, as failure to share relevant information around workplace assessments, return to work programmes, etc, could result in harm to the client, or risk of breach of the Health and Safety in Employment Act or Employment Relations Act for the employer or employee. This creates additional administrative work for vocational rehabilitation compared to other types of single provider work, and this should be compensated.

Proposed Solution:

ACC to fund providers appropriately for all of the work they do, including the multi-disciplinary team consultation and reporting.

Other Specific Gaps in the Contracts

16. Gaps in the Graduated Return to Work ("GRTW") programme include:
 - There is no cover for provision of services outside normal work hours, yet therapists may be required to go into the workplace at any time within a 24-hour period depending on the nature of the work and shift. We believe ACC must support injured New Zealanders by assisting them make a gradual return to work where appropriate. This service should not be denied to shift workers. However its provision should also be the subject of proper remuneration, and penalty rates are a reasonable expectation for cases where physiotherapists are expected to work outside of normal business hours.
 - There is no cover for travelling to remote areas such as Matakana Island, or Waiheke Island. The traditional travel rate of distance, kilometres and time does not cover having to wait for timetabled ferries or weather, and means that a referral that could take six hours instead of the usual one is not reimbursed any more than at the standard rate. Again, ACC should support these people by provision of services including GRTW where needed. If ACC wishes to achieve that goal, it must pay providers on an appropriate basis.
 - There is no funding for the complexity of cases, so that therapists are paid the same rate whether it is more complex and requires much more liaison. This could be include a disparity of up to two hours in assessment time, and up to an additional one to two hours in liaison and report writing time. There has been provision for simple and complex cases in EPN contracts, and we cannot see any reason not to allow for complex cases under occupational health and vocational rehabilitation contracts.
 - There is no cover within the national contracts for peer review associated with clinical reasoning for a particular case, or gaining a second opinion from within that practice. Presently this cost has to be absorbed by the clinic itself, yet can save considerable costs for ACC, as it can lead to reduced time of recovery, the need for second specialist opinion (which may take months to gain), and can prevent development of more complex cases such as secondary chronic pain conditions.
 - Presently there is no funding available for pre-assessment work such as booking of appointments, tracking down the clients (often due to case managers sending wrong or insufficient information). Often the client may have returned to work yet two to three hours of work can have been done by the therapist and this is currently unfunded due to the structure of the contracts.
 - The national contracts are now requiring reports to be sent electronically, yet some ACC Branches are still requiring hard copies. This requires physiotherapists to send in both

electronic and hard copies, which has increased the workload and administrative costs for delivering this service. ACC should ensure that its branches align with its stated policy, particularly where that policy requires heavy investment in IT.

- To date there has been no assistance from ACC in helping occupational health physiotherapists send their work electronically, yet they have supported the GPs to gain the technology to do so. Some physiotherapists have received some funding for sending of electronic remittances, yet direct submission of remittances for vocational contract work is not yet available to physiotherapists delivering vocational rehabilitation. This will require a substantial boost in funding to allow the development of IT capabilities, and most likely a one-off grant in order to allow initial investment in this technology.

Proposed Solution:

ACC to ensure contract rates reflect the entire service requirements and true costs of delivering that service, especially for remote areas, and second opinion type work, which is standard practice in best practice rehabilitation.

Complex Reporting

17. Recent changes to the national contracts has seen significantly more information required for the quarterly reporting, and many therapists will struggle to meet this demand without significantly increasing their administrative support. Yet again there has been no increase in funding to allow for this.

Proposed Solution:

ACC to work with providers to come up with relevant and simple reporting tools that can provide useful information on quality outcomes. The vocational rehabilitation rates should be sufficient to cover this type of reporting requirement.

Better Service Integration

18. The delivery of physiotherapy services generally under ACC has become fragmented due to a variety of contracts being offered which cover different aspects of the rehabilitation of patients to health and capacity. Instead of the seamless integrated delivery of care supported by best practice rehabilitation, ACC has required that physiotherapy practice be split into hands-off and hands-on treatment.
19. This has not happened anywhere else in the world and has led to the situation where a physiotherapist cannot treat the client 'holistically' anymore. If ACC clients are referred for an injury and require intensive rehabilitation, the gym/pool/home programme component will be referred for and funded under an Activity-Based Programme. However this does not allow for any hands-on treatment such as mobilisation and manipulation, and they would need to be treated under the medical fees system for this.
20. This does not allow for best practice quality care and we believe was originally born out of the belief by ACC that 'treatment' needed to be hands-on and delivered in a face to face situation with the client. This is not supported by best practice rehabilitation philosophy, which recognises that rehabilitation is more than hands-on treatment. This should be addressed so that physiotherapists can deliver seamless care without fear of breaching contract and having to work under flawed models of rehabilitation.

Proposed Solution:

ACC to recognise the appropriateness of physiotherapists' clinical autonomy to combine all aspects of best practice rehabilitation, and to work with NZSP to identify and fund appropriate models that truly reflect this best practice rehabilitation.

Approach of ACC

21. The OHPG has generally found the liaison with ACC to be very difficult over the last five to six years. ACC has generally taken a bullying, threatening and dismissive approach to attempts by the OHPG to raise, discuss and address the issues outlined. Over the last 12 months we have seen the down sizing of a number of vocational rehabilitation companies and providers who no longer find it sustainable to work delivering rehabilitation to ACC clients. New Zealand is too small to lose such experienced providers.
22. We support NZSP's view that there must be a strategic partnership between ACC and physiotherapists, which would ensure attitudes collaborative, not negative.

Proposed Solution:

ACC should work positively with NZSP to address the above problems and fund vocational and occupational health services appropriately so that more providers are not lost, and ACC lose access to skilled providers for its clients.

Conclusion

The Occupational Health Physiotherapy Group is pleased to have the opportunity to raise these issues in this review. We believe that the contracts are not a fair reflection of the duties undertaken under them. The nature of the profession and of ACC as a monopoly provider makes individual negotiation of contracts difficult. This places all the more importance on a good relationship between ACC and representatives of providers like this Group. However, ACC has not generally taken a cooperative approach to our concerns.

We believe that there needs to be a dedicated review of these occupational health contracts, just as has been undertaken with EPN. There are many particular features which must be incorporated within payment for these particular contracts. However, we believe that the base for all physiotherapists must be comparable, so that physiotherapists are able to run viable businesses and receive fair remuneration whether under an EPN contract, a vocational rehabilitation contract, or any other arrangement with ACC.

Finally, whilst we agree with the provisions of occupational health and vocational rehabilitation, we feel that ACC must continue to work with physiotherapists to review whether this treatment is becoming too isolated. Continued development of service delivery models by both the profession and ACC working together is in the best interests of patient health and welfare.

Lee Gardiner



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