Improving Recovery Outcomes for Injured Workers

Insights and Recommendations Final Report
May 2022

THE *BEHAVIOURAL* ARCHITECTS

WorkSafe VICTORIA

Notes about this report

- This report was produced by The Behavioural Architects following research commissioned by WorkSafe Victoria
- All healthcare providers were invited to participate in the research

What have WorkSafe actioned following the research?

Many of the recommended jobs to be done aligned with work underway or planned within WorkSafe. Therefore we reviewed current and planned activities against recommendations. We identified:

- Activities are already underway that align closely with some recommendations
- Opportunities to improve planned activities based on the research findings

What next:

- Continue to translate research findings into ongoing work
- Create design principles that assist project teams to incorporate findings into future work
- Continue to explore opportunities for new work to address identified factors

Contents

THE BEHAVIOURAL ARCHITECTS

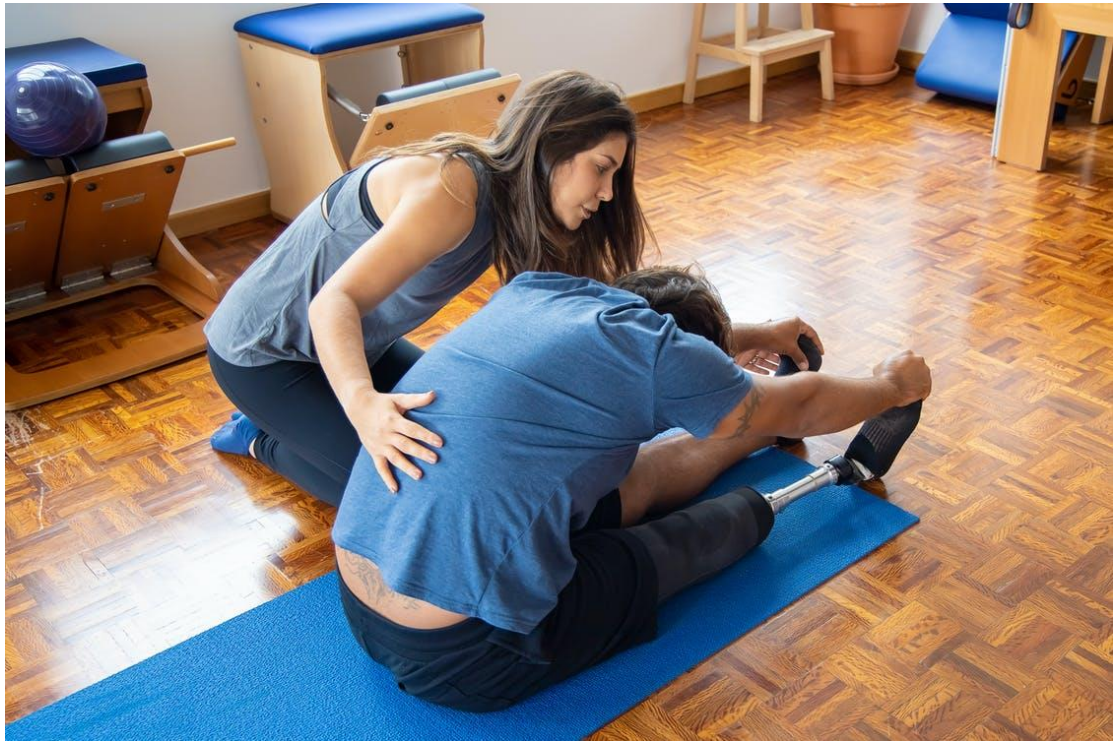
1
Background, objectives and methodology

Project background

WorkSafe Victoria wants to ensure that Injured Workers with compensable injuries receive high quality treatment which delivers positive treatment outcomes beyond returning to work alone.

Research has consistently demonstrated poorer recovery outcomes for Injured Workers treated over the compensation schemes than those with comparable injuries outside these schemes: Over time there has been a continued trend toward workers receiving more treatment but experiencing longer recovery times.

WorkSafe is now focused on identifying factors which contribute to quality of care by assessing the challenges faced by Treating Healthcare Providers (THPs) when providing treatment.



Behavioural Objective

For THPs to provide high quality treatment to compensable injured workers that primarily focuses on optimal biopsychosocial recovery outcomes and as a result facilitates successful recovery and return to work.

A three-phase approach

PHASE 1 - DEFINE

Review materials to understand behavioural factors and unconscious biases that can influence a THP's ability to deliver quality health treatment and contribute to improved recovery outcomes for Injured Workers.

PHASE 2 - DISCOVER

Primary research to understand behavioural factors and unconscious biases that can influence a THP's ability to deliver quality health treatment and contribute to improved recovery outcomes for Injured Workers.

PHASE 3 – DEVELOP

Collate insights and design interventions that support THPs to provide treatment that contributes to improved recovery outcomes for Injured Workers.

Our Methodology

The Discover Phase consisted of two stages

A

THP Quantitative Survey

An online survey to understand the triggers and barriers to optimal care.

The survey was sent by WorkSafe Victoria and peak bodies to THPs who currently treat compensable Injured Workers through email and social media.

The respondents could choose between completing a shorter 10-minute version of the survey or a longer 20-minute version. 55% chose the longer option and 45% chose the shorter option.

The sample consisted of n= 70

- n=3 GPs
- n=8 Psychologists
- n=2 Psychiatrists
- n=3 Chiropractors
- n=9 Other
- n=28 Physiotherapists
- n=7 Exercise Physiologists
- n=6 Occupational Therapists
- n=4 Osteopaths

Please refer to appendix V for quantitative survey questions and data

B

In-depth interviews with THP's

To further explore in detail the key triggers and barriers for THPs to provide high quality treatment to compensable Injured Workers, as well as helping us understand the “why” behind the quantitative survey findings.

Interviewees volunteered to participate by submitting their contact details at the end of the THP Survey

The sample consisted of n=14

- n=1 Specialist occupational physician
- n=1 Sport and exercise physician
- n=2 Psychologists
- n=1 Chiropractor
- n=3 Physiotherapists
- n=3 Exercise Physiologists
- n=2 Occupational Therapists
- n=1 Osteopath

Please refer to appendix VI for in-depth interview discussion guide.

Please note – as the quantitative sample was too small to call significant, this report is lead by qualitative and behavioural science insights, rather than quantitative data

Quantitative data where relevant is signposted throughout the report in green boxes.

We designed the proposed interventions through customer brainstorming, insights and application of BeSci

Ideas generated in interviews

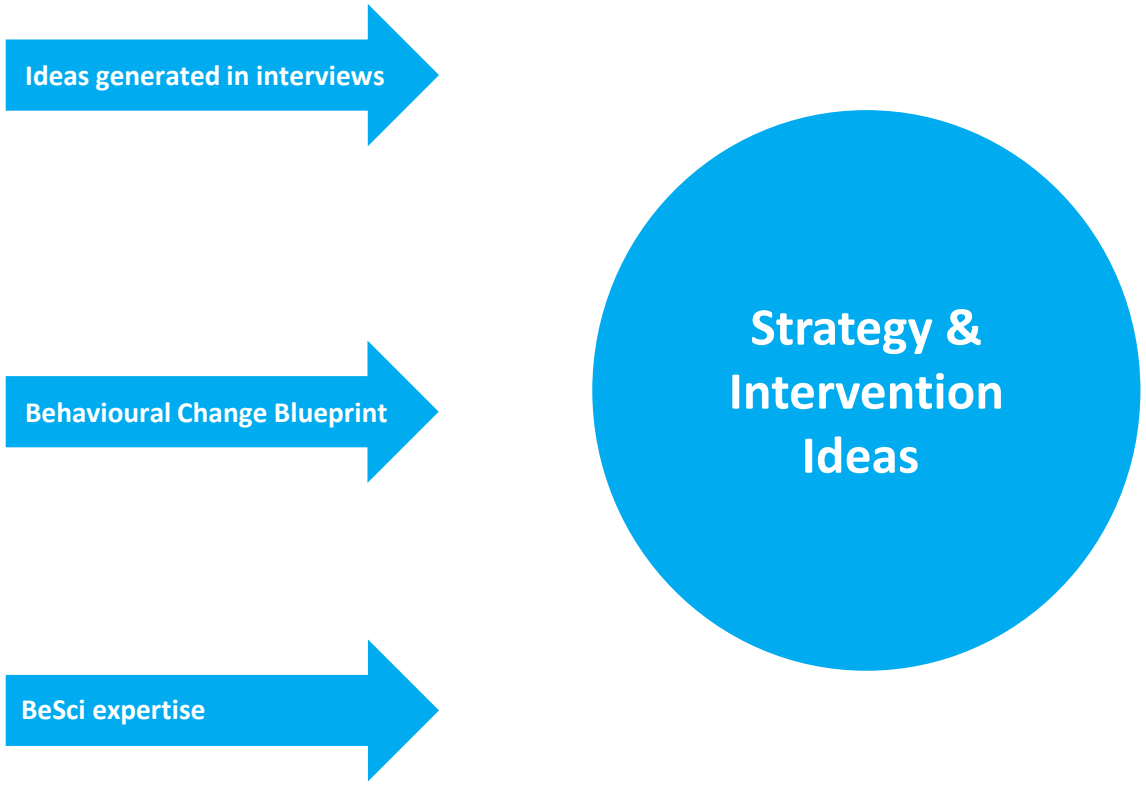
Throughout in-depth interviews with THPs, we took onboard insights on the flow of treatment, where within that treatment journey triggers and barriers to optimal care exists, and THPs recommendations for interventions, as well as their feedback on proposed interventions. Survey insights were also integrated at this stage.

Behavioural Change Blueprint

Throughout the design of the Behavioural Change Blueprint, key weaknesses were identified. The interventions were designed to support and overcome those weaknesses in the behavioural journey of treatment.

BeSci expertise

Using our knowledge and expertise in behavioural science (BeSci), we identified behavioural principles that could be leveraged to overcome key barriers to optimal treatment.



2
Executive Summary

There are particular elements of the system which either help or hinder THPs to help Injured Workers effectively progress through their recovery journey

There are 4 key factors supporting optimal treatment

Flexibility	When the compensation system allows for decisions at the discretion of THPs, the flexibility permits treatment tailored towards the individual needs of Injured Workers.
Evidence	Evidence-based treatment increases consistency of THPs' treatment and can reassure Injured Workers about the quality of their treatment.
Accountability	Frequently reporting on effectiveness of a treatment approach promotes critical assessment of the chosen treatment.
Support	Receiving support with tasks that can be done by others enables THPs to focus on those tasks that require their expertise

And 4 challenges faced by THPs

Multiple Roles	THPs need to fulfill too many roles that are not directly linked to their expertise to achieve high quality of care.
Communication	Poor communication stemming from lack of time and mismatch of availability hinders informed treatment leading to optimal care. Lack of trust between stakeholders and perceived ulterior motives further hamper collaboration.
Assessing Progress	THPs treat without fully taking factors into account that are required to achieve biopsychosocial recovery and patient goals.
Overconfidence	The lack of critical re-evaluating of prescribed treatment and self-assessment skills that do not directly related to the profession leads to poorer treatment outcomes.

There are 7 jobs recommended to overcome these challenges

1 Empower Injured Workers

When Injured Workers are actively engaged in their treatment, it helps them to overcome barriers to recovery.
Empowering Injured Workers, by giving them relevant information to make their own decisions increases engagement, motivation and speeds the recovery process.

2 Create supportive roles

The treatment of Injured Workers is the result of collaboration between THPs, admin staff and loved ones at home and THPs are not able to do everything themselves.
This is why it is necessary to foster roles that will support THPs providing treatment and navigating the compensation scheme and support roles for Injured Workers at home.

3 More nuanced reimbursement

The current remuneration structure makes THPs feel undervalued and underpaid for the extent of the work that they do. They are unmotivated to do essential admin work, communication and joining the compensation scheme in the first place.
Making remuneration more-targeted towards expertise and tasks completed will improve motivation to provide optimal care.

4 Timely reminders

Stakeholders involved in care, including THPs and case managers, inadvertently delay treatment by not responding to requests from one another or carrying out appropriate tasks, such as reassessment of symptoms.
Prompts, to be given at the right moment in time, are less likely to be ignored and so will create a safeguard against unnecessarily delayed treatment.

5 Increase transparency of treatment

The treatment of an Injured Worker by all treating THPs are often obscured from one another, meaning THPs are working off incomplete or inaccurate information relayed by the Injured Worker.
Making treatment plans more transparent and facilitating greater collaboration between THPs will improve accuracy of their information, thereby fostering a more holistic treatment program.

6 Streamline admin processes

The extent of and difficulty in completing and submitting reports, treatment plans and other admin is a common complaint among THPs.
It is therefore vital that friction is removed from the system, making it easier and quicker to do the required work.

7 Equip THPs with soft skills

THPs are over reliant on existing knowledge and expertise which often don’t adapt to changing research or guidelines.
Supporting THPs to find relevant information and forming new treatment habits will ensure Injured Workers are receiving the best quality care.

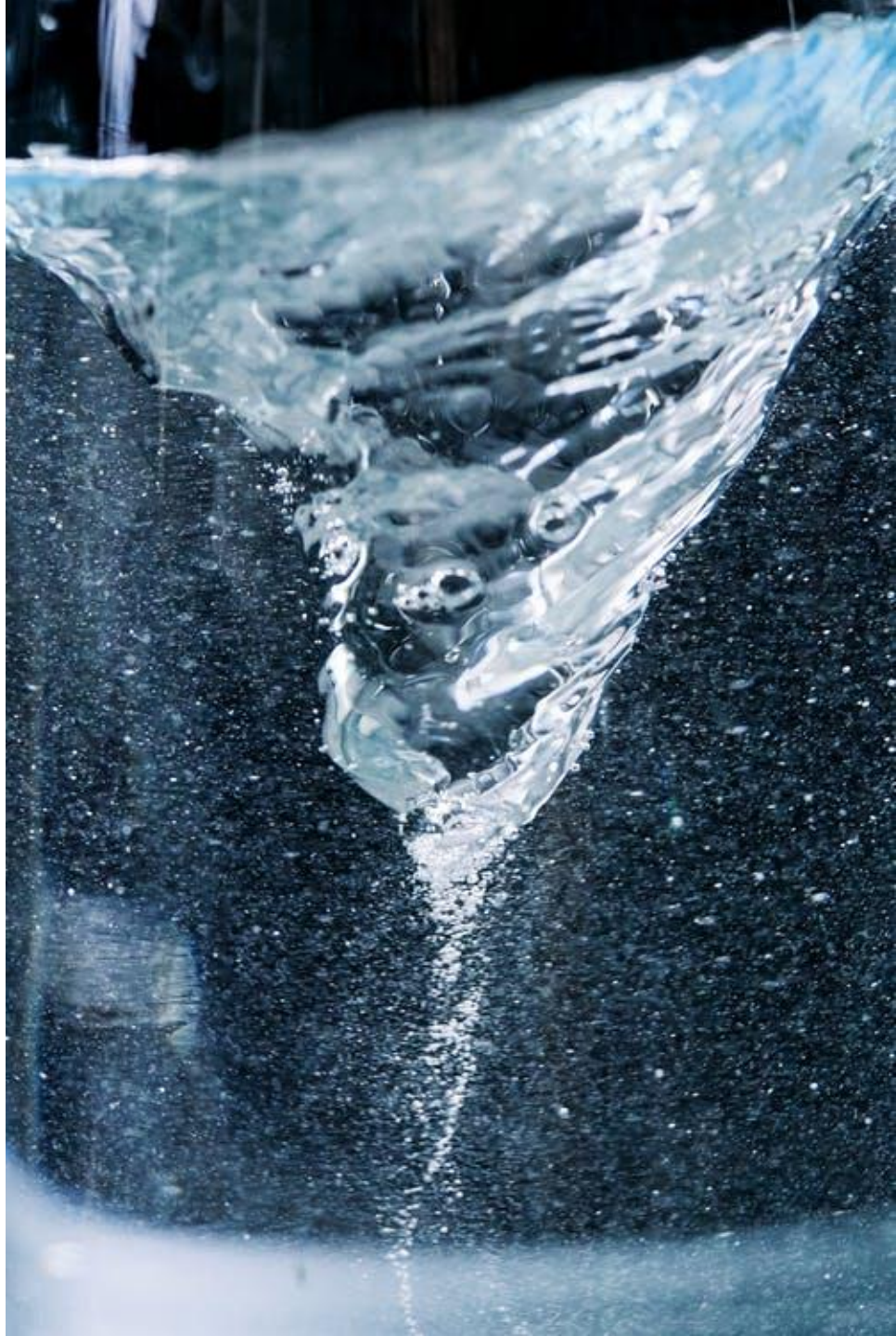
3

Framework of the treatment journey

Compensable injured Workers receive more treatment but consistently show poorer outcomes and longer recovery times compared with non-compensable patients.

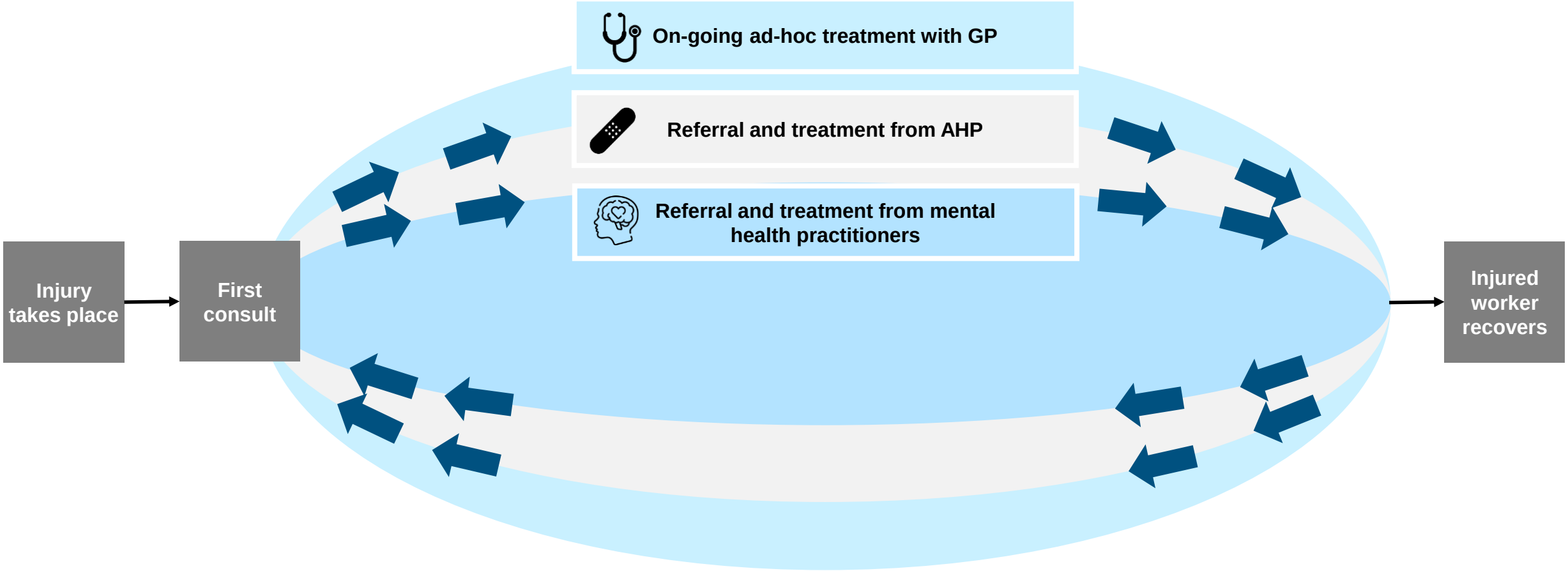
(RACP, 2010; IPAR, 2017)

Injured Workers can get pulled into the system, going round in circles of waiting and referrals whilst getting further away from where they might need to be.



As a result, and by nature of the situation, the treatment of Injured Workers in the compensation system is often a non-linear journey

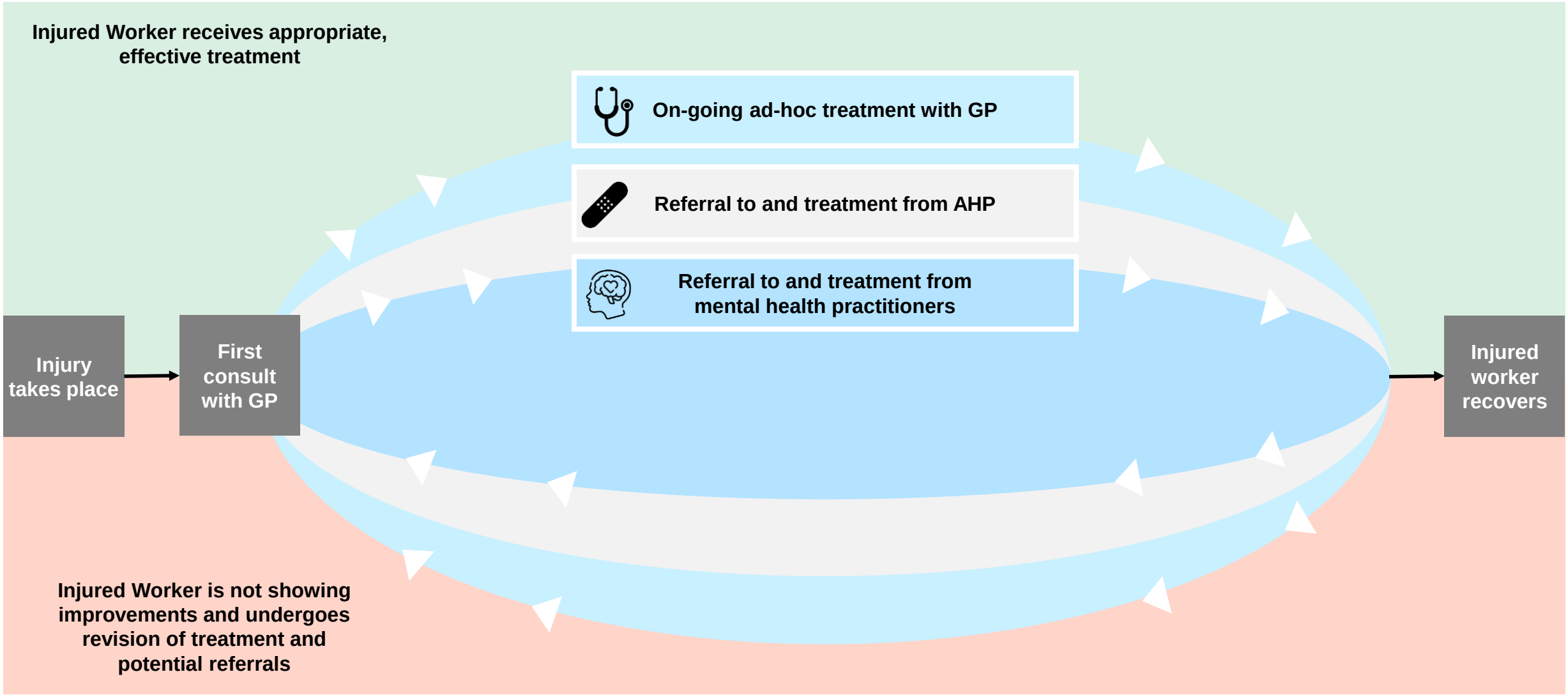
There are three main treatment cycles, which consist of:



The cycles can be entered **consecutively** (GP referring on to a THP who might then request mental health services) or in **parallel** (treatment from the three main groups concurrently).

Suboptimal treatment can lead to endless rotations with simultaneous or interchanging course on parallel cycles, with multiple THPs treating the Injured Worker concurrently.

It can be difficult to leave the treatment cycle and achieve optimal outcomes



There are many factors that influence how often Injured Workers travel through treatment cycles

We found that THPs who treat Injured Workers take on too many different roles to comply and support Injured Workers with navigating the compensation system.

The WorkSafe compensation system promotes that progress is assessed against goals that are not the priority for Injured Workers, thus, not posing the right motivation and target point for treatment.

Slow approval processes and poor communication between THPs delay appropriate treatment and exacerbate injuries, ultimately extending the recovery process and deteriorating Injured Workers' mental health. Poor mental health further slows down recovery and return to work.

It is important to remember that Injured Workers play a vital role in achieving their own optimal and fast recovery outcomes

How Injured Workers think and feel throughout their treatment journey and about their treatment plan impacts how fast they can progress.

A mindset of wanting to improve, feeling the ability to show strength rather than having to prove illness, or wanting to return to work quickly allows full focus on recovery.

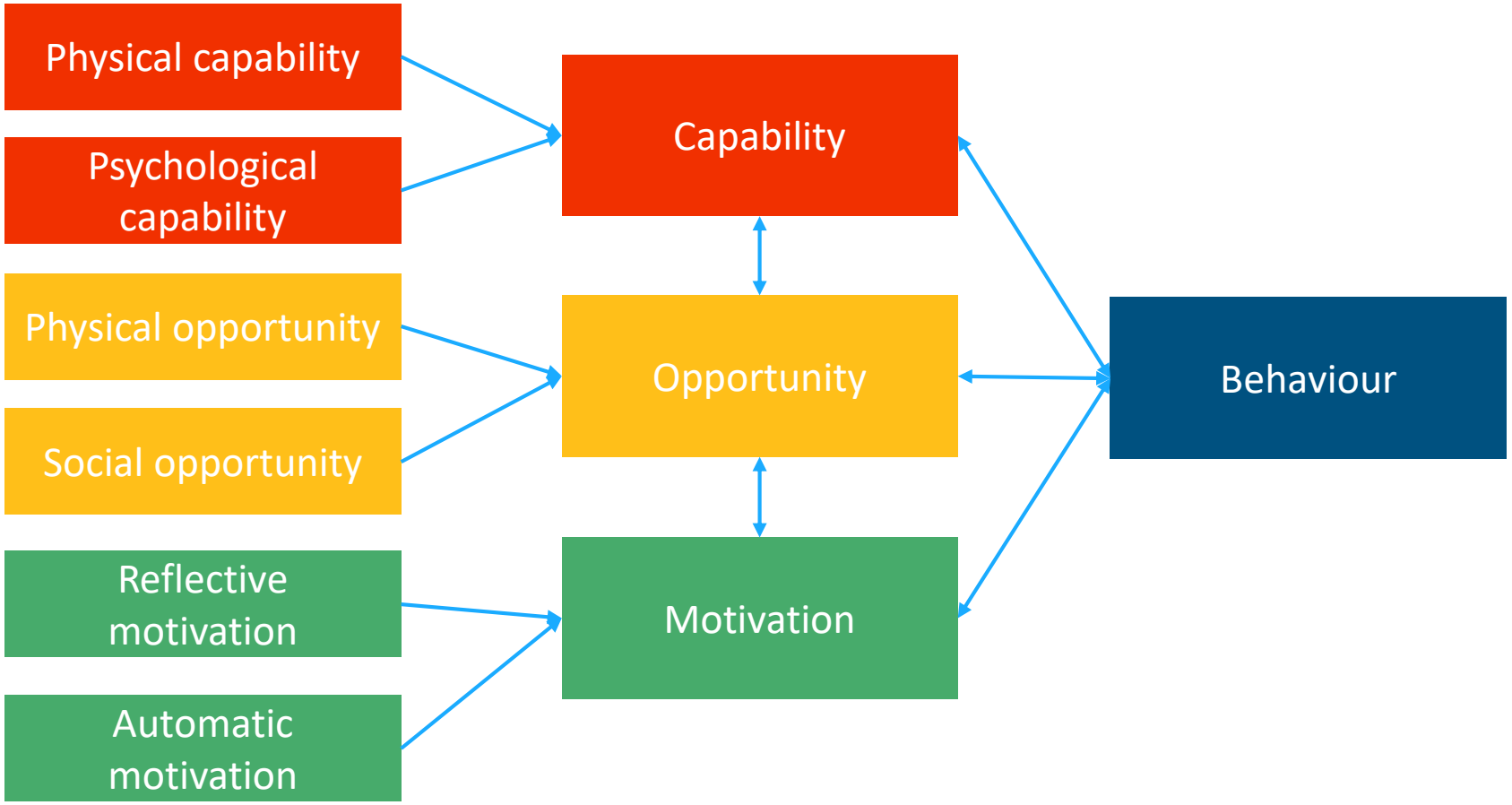
Injured workers are also powerful helpers to THPs for directing treatment towards overcoming barriers.

> “Sometimes to get compensation claim, [Injured Workers] have to prove how injured they are. Them having to prove how sick and injured they are for months, or years means I can not treat them to get better. ”
> *Exercise Physiologist, practice size 1-5, regional*

To ensure a robust intervention strategy, we have utilized the COM-B model

We have used the model to further explain barriers and what aspects interventions must improve on to achieve optimal quality of care.

Further information on the individual components of Capability, Opportunity, and Motivation can be found in the appendix.



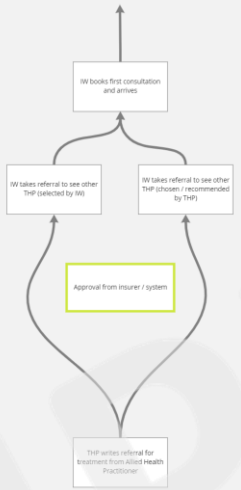
Throughout the report, we will mark when a trigger, barrier or intervention relates to Capability **C**, Opportunity **O**, and Motivation **M**

4
Triggers and barriers to providing optimal treatment

Trigger/Barrier: [Insert theme]

How to read the following slides - The key insight and implication is written in the heading here

The main body text further outlines the insights and implications, explaining what has been found and how it impacts quality care and recovery.



We have placed COM-B call outs on the slide for what the trigger/barrier relates to, e.g. C for Capability

C

Some slides may have a segment of the Behavioural Change Blueprint (Theory of Change logic) captured to indicate where in the specific treatment journey this takes place.

Green boxes like this one flag any quantitative insights which support the qualitative or BeSci findings.

"Quotes from the qualitative interviews that support the insights are here."
Including the demographics of the participant

Behavioural science principle

Many of the triggers or barrier discussed have underlying or interconnected behavioural science explanations or implications. These callouts include an explanation of the BeSci principle and how it is impacting THP / IW and quality of care.

The current system supports optimal treatment in 4 key ways

C

Trigger: Flexibility

Injured Workers not being preoccupied with reimbursement aids recovery

Not worrying about finances allows focusing on recovery and reduces worry-related issues with mental health

- When an Injured Worker is not concerned about their compensation, they can direct their focus on resolving issues.
- Weekly payments reduce the development of anxiety and depression relating to worries about loss of income.
- Having financial support approved quickly means that Injured Workers don't further need to prove that they are very injured and can focus on recovering as fast as possible.

"Sometimes to get compensation claim, they have to prove how injured they are. Them having to prove how sick and injured they are for months or years, I cannot treat them to get better. They get into this sick role or victim role. That can be something really hard to break through. Their identity becomes consumed by being the sick person. Because that's how the compensation system works."
Psychologist, practice size 1-5, metro

"[Being on compensation did not make treatment more difficult in this case] because the patient wasn't particularly interested in compensation itself but was interested in resolving issues."
Occupational therapist, practice size 10+, metro

Cognitive Strain

When people must make too many effortful and conscious System 1 decisions.

Worrying about living expenses involves much planning and consideration for hypothetical scenarios. This can be mentally exhausting and impact the resources they have to focus on treatment.

C

Trigger: Evidence

Basing treatment on evidence promotes trust

The Clinical Framework promotes patient trust and consistency

- THPs reported that learning that their treatment is evidence-based can reassure Injured Workers about its quality
- Evidence-derived guidelines promote consistency across treatment
  - ✓ THPs are more likely to follow a treatment approach if it is evidence-based
  - ✓ THPs who disagree with the treatment of a co-treating THP can be presented with evidence supporting that treatment

"They help Injured Workers with consistency, knowing people follow best advice and it's evidence based. Those factors help a lot for patients. GP might have told them something conflicting. Can go back to GP with framework or guideline.. Helps with conflict."
Chiropractor, practice size +10, regional

"Anything that gets everyone on the same page has to be good."
Specialist occupational physician, practice size 1-5, metro

Power of Because

People are more likely to agree to something when simply given a reason.

More trust from Injured Workers around their treatment plan means greater compliance.

M

Trigger: Accountability

WorkSafe holding THPs accountable increases the quality of treatment

Regular assessments mean that THPs must regularly self-assess the success of their treatment approach.

- THPs' progress with the Injured Workers gets externally assessed whenever they submit a report.
- The regular requirement of receiving approval means that THPs must constantly make progress and prove efficacy of the treatment they are proposing, increasing their motivation to re-evaluate their treatment pathway.

"Sometimes it works beautifully, if approvals and referrals are in place. Professions are required to constantly make steps forward. That is helpful. Regular accountability of getting treatment cycles approved."
Exercise Physiologist, practice size 1-5, metro

Overconfidence Bias

When subjective confidence is reliably greater than objective accuracy. We are generally programmed to like confident, optimistic people.

Having to justify their treatment success to others allows for a more objective assessment.

O
M

Trigger: Support

THP admin staff alleviates time burden

Admin staff can support THPs with tasks that are time consuming and do not require a THPs expertise.

- THPs admin staff can facilitate communication with case managers.
- THPs who have admin staff that submits reports perceive the overall completion of reports as less burdensome.
- The removal of administrative tasks frees up time for THPs to attempt communication with other THPs that is treatment specific, treat more Injured Workers, and might motivate them to write more elaborate reports.

> "Injured Workers normally have case manager on file, and we send it directly to them by email or fax. Our admin does it."
> *Exercise Physiologist, practice size 1-5, regional*

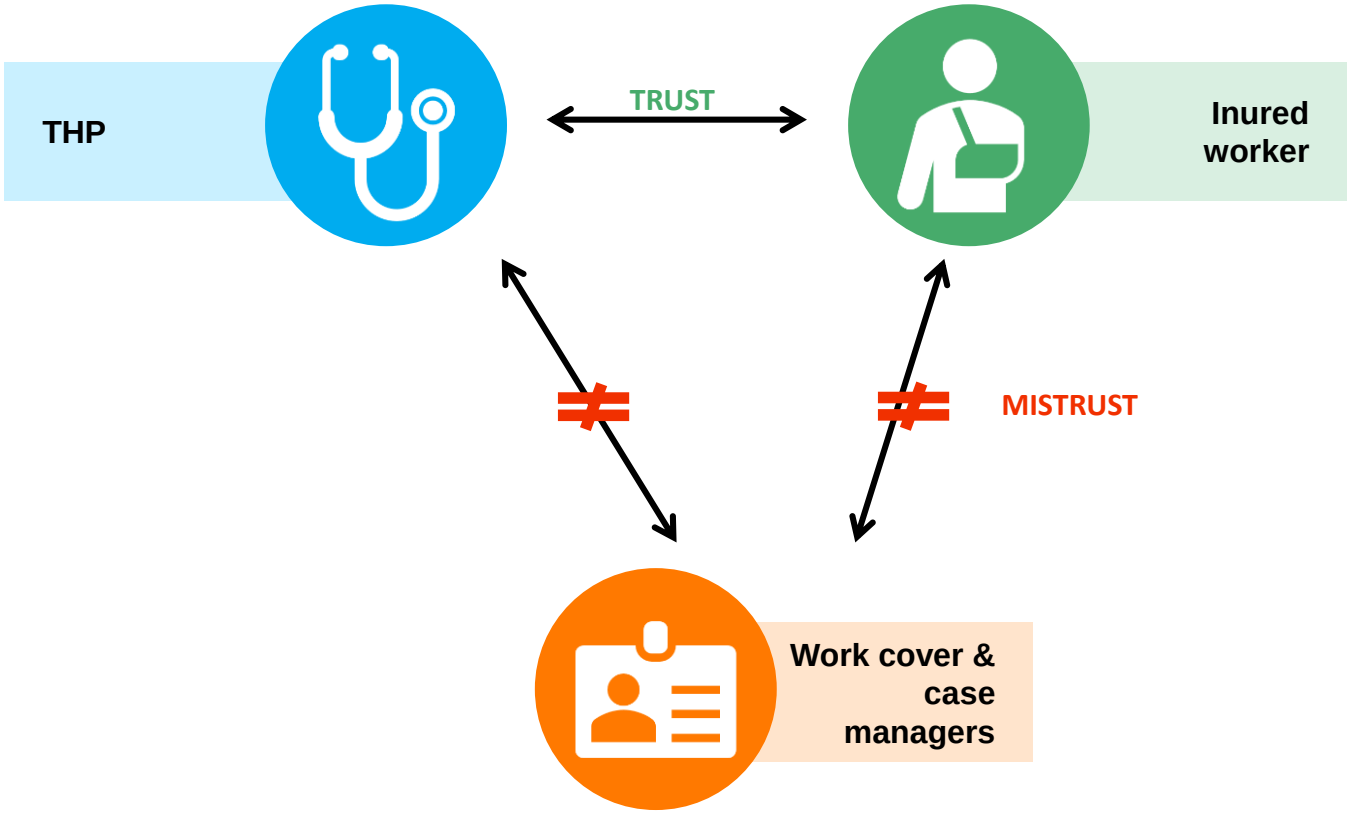
> "I need to find someone's email address; they change a lot. You get no response, get no acknowledgement. If you knew it was submitted. Would save a lot of time."
> *Osteopath, practice size +10, metro*

Choice Architecture

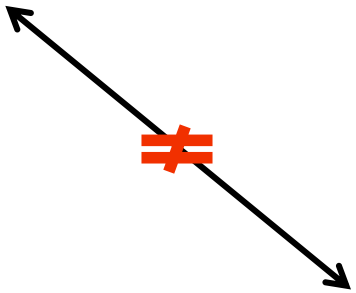
Our decisions are influenced by the way choice is presented to us – all choice is relative.
THPs may choose to write a more elaborate report if they do not anticipate following effort around sending the information.

An overarching challenge is the lack of trust in optimal quality of care being others' primary objective

Mistrust between key parties impacts THPs' ability to treat Injured Workers and Injured Worker recovery



Mistrust between THPs and systems / WorkCover



THPs believe that some case managers have ulterior motives other than the optimal treatment of Injured Workers.

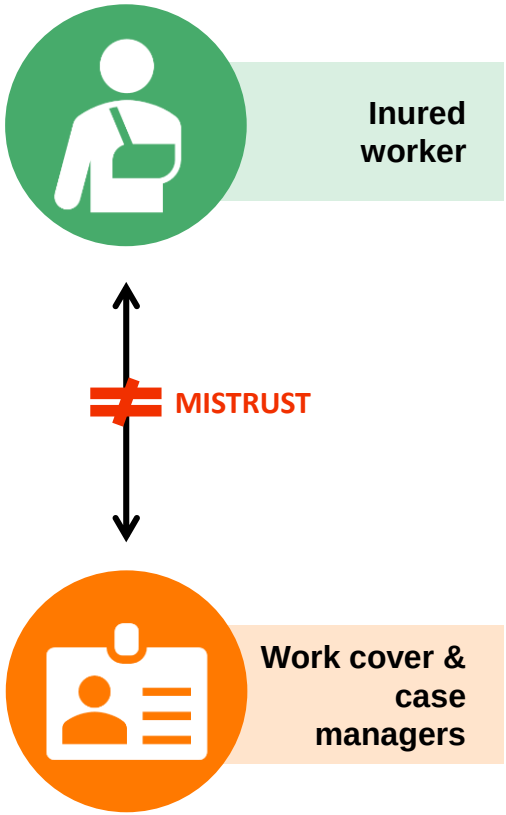
This may impact what is included in treatment plans or reports, not reflecting the true injury, if THPs expect the optimal treatment would not be approved because it would take too long or is too expensive.

"Insurance providers and rehab providers claim [they are psychologists when they are not], they are employed by insurer to get person back to work. When people are not physically or mentally ready, it is not the time. It is about performance money they get. Any time I had a rehab provider in my office it has been detrimental. They take minutes and usually write inaccurate reports."
Psychologist, practice size 1-5, metro

Mistrust between Injured Workers and case managers

- Injured workers feel pressured to be proving how injured they are, forcing them into a social identity which can have detrimental consequences to their mental health and everyday functioning.
- Some report that the suspicion of fraud can drive case managers to measures that hinder recovery, such as surveilling Injured Workers near their homes to investigate if they are truly injured. Even if not always the case, awareness of such practices, in turn, limits trust by Injured Workers towards their agents and negatively impacts their mental health and recovery.
- This pressure impacts their engagement in treatment and can at times make the injured worker not participate so they can provide legal evidence to their injury, which makes it difficult for THP to treat injured workers.

"You lose faith, trust, are suspicious of everyone in their motivation. WorkCover spent 12million/year pushing detectives on people who have injuries: take photos of people in their house. Ended up trailing [Injured Worker] to gas station and wrote a 10-page report of that. There is a stigma, people feel judged as liars."
Psychologist, practice size 1-5, metro



Increasing trust is a challenging goal to achieve and should be viewed as a long-term objective.

Trust must be slowly increased over time and be considered throughout the implementation of all interventions.

THPs take on too many roles

Barrier

1 THPs invest too much time explaining the compensation system and treatment frameworks

What is currently happening?

Many THPs spend time counselling Injured Workers on details of the compensation system and roles of other THPs.

What are the consequences?

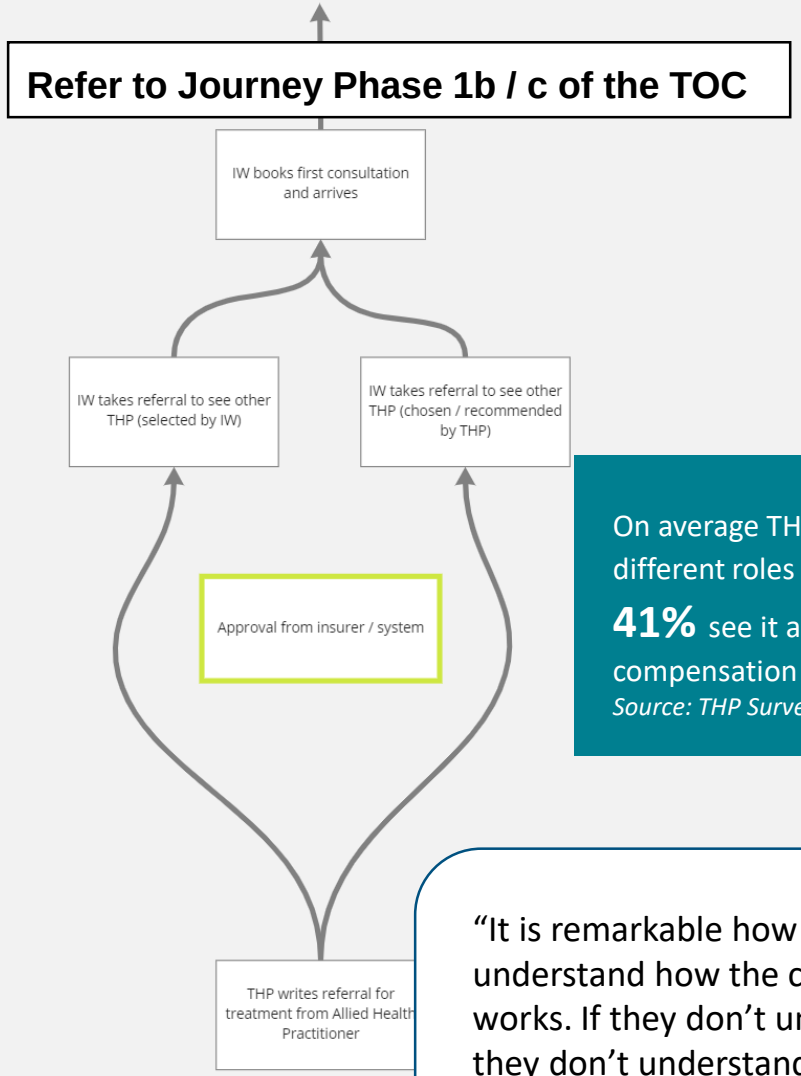
- It takes time away from treating the injury.
- It reduces available time for providing injury-specific counselling.
- It may lead to incorrect information being conveyed to the Injured Worker.

When does the issue arise?

The issue persists throughout the treatment journey but is greatest at the beginning when Injured Workers are novel to the procedures

Planning Fallacy

THPs are overconfident in their ability to fit everything into a single consultation leading to too much spent on a single area, in this case, explaining the compensation system



On average THPs identify with over 5 different roles and

41% see it as their role to explain the compensation system to Injured Workers

Source: THP Survey

"It is remarkable how few people understand how the compensation system works. If they don't understand the system, they don't understand the approval process, they then get angry which affects motivation."

Sport and Exercise Physician, practice size 0, metro

2 THPs need support outside of the practice to help motivate Injured Workers

What is currently happening?

THPs provide Injured Workers with tasks, exercises or medicine to take in between treatment sessions.

Injured workers at times do not comply with the prescribed treatment because they suffer from low motivation due to mental health, social barriers and strain, or finances and complications with compensation.

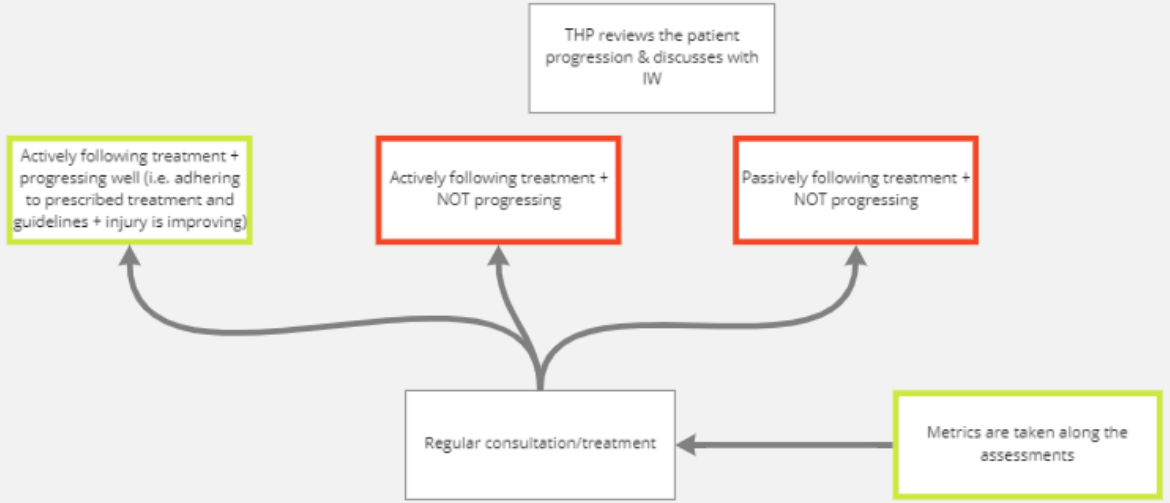
What are the consequences?

- Healing time is extended, and recovery does not progress.
- The injury may worsen as it is not treated appropriately.
- Injured Workers' mental health further deteriorates as their situation is not improving.

When does the issue arise?

The issue may arise early in the treatment journey or at any other time throughout and worsens over time if not attended to.

Refer to Journey Phase 5a-c of the TOC



"The strain on relationships can be huge and when relationships break down at home, people don't feel like they are able to get better."
Physiologist, practice size 6-10, metro

3 Administrative tasks and communication are perceived as not being appropriately reimbursed

What is currently happening?

Administrative tasks and communication are not completed in a timely manner because of a lack of reimbursement. This includes additional forms Injured Workers need completed compared to non-compensable workers, case conferences, communicating with other THP and requests / needs from case managers and agents.

What are the consequences?

- THPs do not take on Injured Worker cases as they don't feel properly reimbursed for their time, particularly GPs and experienced THPs
- Treatment is slower and less coordinated, as payment for this time is not included in reimbursement

When does the issue arise?

Throughout the Injured Worker journey this is a challenge, particularly if the case becomes extended.

This is a particularly strong issue for smaller practices where there is not administration staff to submit forms, reports and manage reimbursement.

Loss aversion

THPs currently feel that they are losing time and financial gain by working on Injured Worker cases, making them less motivated to take and properly attend to Injured Worker cases

"I do the forms with them in the session, it takes time away from it but it's the only way to get it done and be reimbursed for it. Or if I can't do it in the session, I do them all at the end of the day in one go."
Physio, practice size 6-10, metro

4 THPs perceive Injured Worker cases as not properly reimbursed for not considering expertise

What is currently happening?

THPs perceive compensation for Injured Worker cases as poor compared to the extra level of time, effort and stress it induces when it doesn't take into account the level of expertise and tenure that THPs can have in their field, paying only the base rate.

As a result, experienced THPs often refuse Injured Worker cases, and this can cause a delay in referrals to find a 'good' or experienced THP willing to treat the Injured Worker.

What are the consequences?

- THPs are reluctant to become involved in Injured Worker cases and the perception and negativity to Injured Worker cases remains
- There are delays in the referral process, stopping Injured Workers getting the immediate and effective treatment that they need

When does the issue arise?

This issue arrives primarily at referral stages/ first consult, where a THP may refer them on to someone else and the Injured Worker can have difficulty in finding someone appropriate.

"It is mentally demanding to see people in that space and feeling undervalued and being paid less than people in other schemes is difficult and demotivating."
Exercise physiologist, practice size 6-10, regional

"I don't take Injured Worker cases anymore – I've made a few exceptions if they want to pay the gap and I help the junior staff with their questions, but otherwise I don't get involved. I've got 30 years experience and it just doesn't cover my experience and the time taken."
Physio, practice size 6-10, metro

Communication is fraught with difficulty

Barrier

5 Approvals for treatment are significantly delayed

What is currently happening?

Approval requests take anything from 2 weeks to 12 months to be processed.

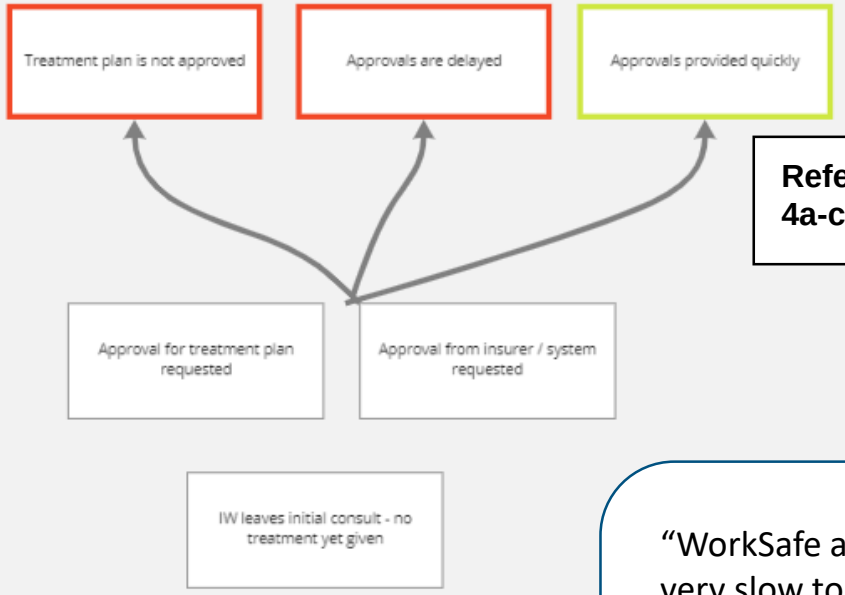
Often case managers are too busy or additional clarification is needed which requires extra communication and time from the THP.

What are the consequences?

- Injured Workers are not able to proceed in their recovery journey.
- Without an understanding of the compensation system, the Injured Workers become demotivated, less actively engaged and stop improving.

When does the issue arise?

After initial consultation and treatment plans are created or once a THP has identified need for a change in approach with new treatment or referral requests.



Refer to Journey Phase 4a-c of the TOC

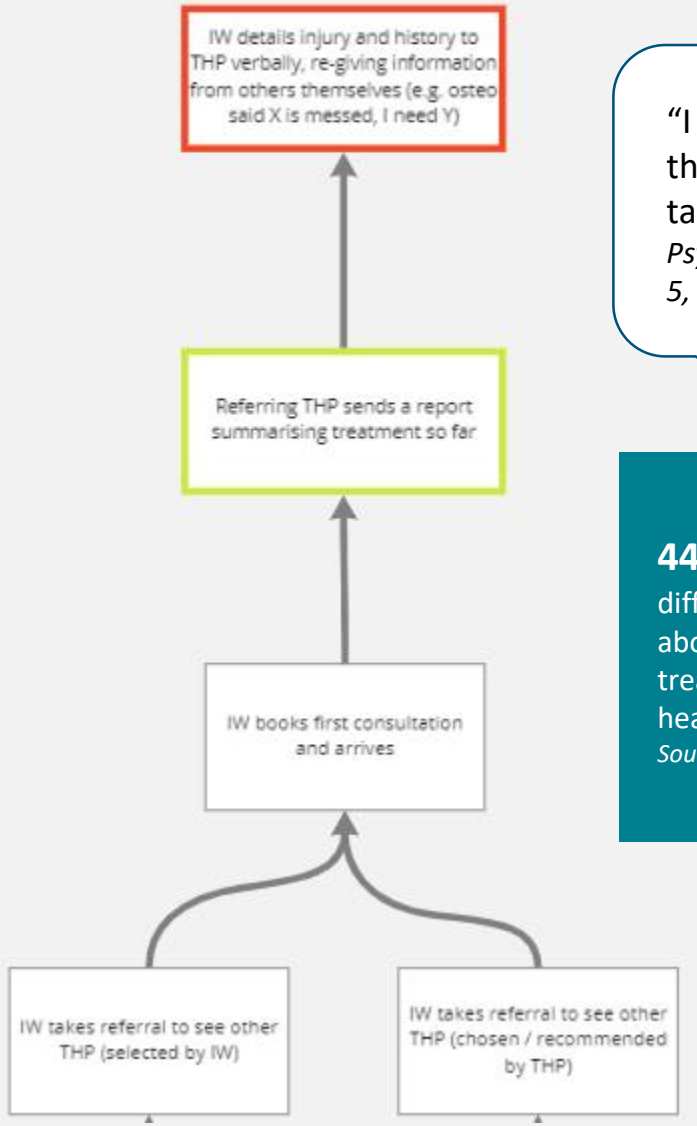
60% of THPs believe it is difficult to communicate with case managers
Source: THP Survey

"WorkSafe agents are often very slow to approve treatment plans causing delays in treatment and adding to psychological stress."
Occupational Therapist, practice size more than 10, metro

"For instance, if I have made recommendations to purchase equipment, or gym membership, it might take two months for them to approve the funding. The delay in response means a delay in recovery trajectory."
Exercise Physiologist, practice size 6-10, metro

6 THPs have difficulties determining the treatment plans of other THPs

Refer to Journey Phase 1b / c of the TOC



"I tried to call physio and then we did this phone tag thing."
Psychologist, practice size 1-5, metro

44% of THPS believe it is difficult to get information about the Injured Workers treatment from other healthcare providers
Source: THP Survey

What is currently happening?

THPs sometimes, but not always, receive a letter from the referring THP detailing their previous treatment. If details are unclear, THPs often unsuccessfully make calls or ask Injured Workers to relay how they have been treated in the past.

What are the consequences?

- THPs may base their treatment plan on incorrectly recalled or insufficiently detailed information provided by the Injured Worker.
- THPs have insufficient information to derive an ideal treatment plan

When does the issue arise?

The issue arises when an Injured Worker begins treatment with a new THP

Diffusion of Responsibility

THPs believe it is the responsibility of someone else to communicate treatments leading to nobody taking responsibility for this vital task.

THE BEHAVIOURAL ARCHITECTS

THPs treat without assessing progress

Barrier

7 THPs inconsistently take early metrics to measure injuries

What is currently happening?

Many THPs are not measuring the current state of the injury incurred and if they are, they often stick to measuring injuries within their own specialisation rather than taking a biopsychosocial approach.

What are the consequences?

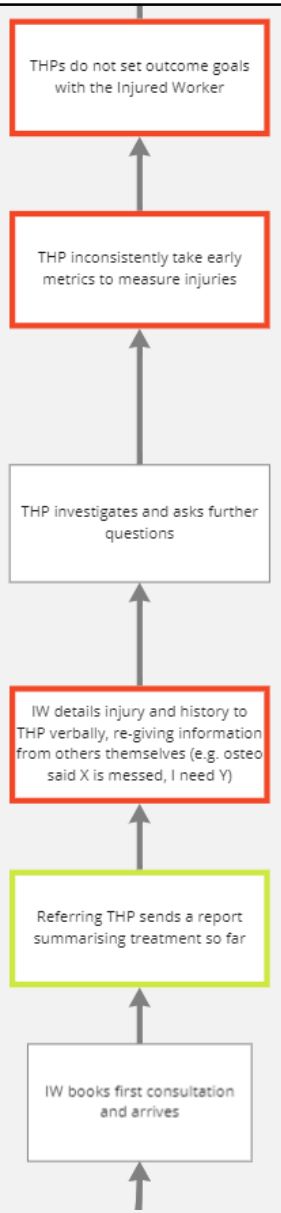
- It makes it difficult for THPs to assess biopsychosocial factors.
- If biopsychosocial factors are not assessed, they can't be addressed within treatment plans and essential referral aren't made.
- It is challenging to identify progress as future measurements do not have a clear comparison.

When does the issue arise?

During the primary consult between an Injured Worker and a THP

Habits
THPs rely on routines when assessing patients. These routines currently do not include taking metrics at the start of treatment

Refer to Journey Phase 2a-c of the TOC



A third of THPs think that other THPs find it difficult to measure symptoms and social risk factors that are outside their area of expertise
Source: THP Survey

"I take a history to understand what the injury might be, examine her, and talk about psychosocial elements but I don't take any measurements."
Sport and Exercise Physician, practice size 1-5, metro

8 THPs do not often set recovery goals with the Injured Worker

What is currently happening?

Some THPs are goal setting with the Injured Workers but this is not consistent across specialisations.

Many THPs will instead only discuss current injuries and ongoing treatment without mention of long-term recovery and target progress.

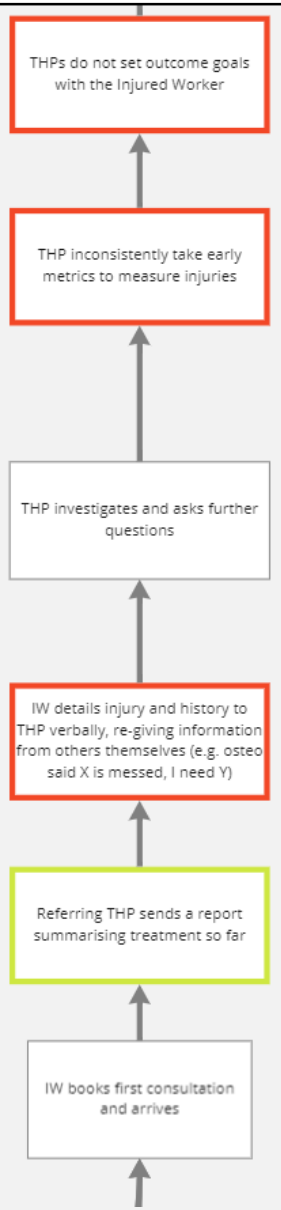
What are the consequences?

- Injured workers are unaware of their expected outcomes.
- Without targets to aim towards, motivation and engagement with the treatment process can be low.
- THPs lack clarity on where their treatment should be progressing towards.

When does the issue arise?

During the primary consultation between an Injured Worker and a THP

Refer to Journey Phase 2a-c of the TOC



"There is the return-to-work-plan but no log for Injured Worker goals. Maybe that is where the disconnect lays."
Psychologist, practice size 1-5, metro

79% of THPs define progress as the Injured Workers achieving recovery goals set by the THP.
Source: THP Survey

Overconfidence fosters a lack of self-evaluation

Barrier

9 THPs are overconfident in their ability to determine optimal treatment plans

What is currently happening?

More experienced THPs rely on perceived expertise and prior experience to develop a treatment plan rather than referencing best practice, the clinical framework or other guidelines. THPs newer to the compensation scheme are, however, unsure of determining the best treatment.

What are the consequences?

- THPs form poor habits in terms of treatment plans with little adaption to changing guidelines over time.
- Injured workers are not provided with an optimal treatment plan which can slow and hinder recovery.

When does the issue arise?

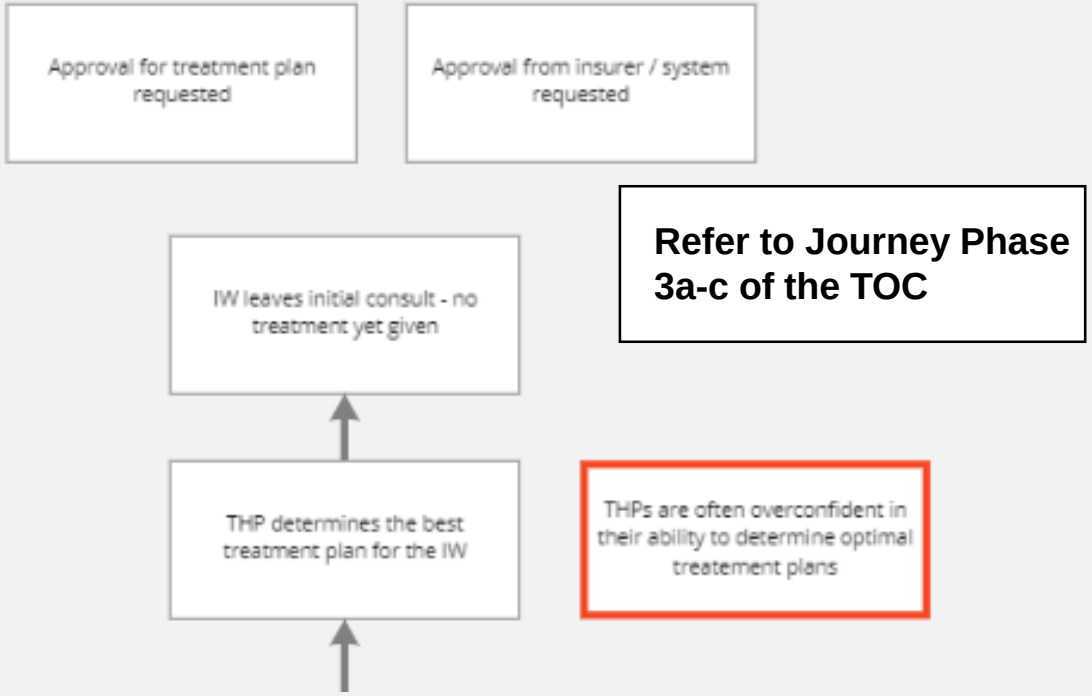
When determining the treatment plan following a primary consultation.

Overconfidence Bias

Subjective confidence is reliably greater than objective accuracy.

91% of THPs agree that they know how best to treat Injured Workers but **39%** believe that other THPs don't know the best next steps for patients with psychosocial symptoms. There is a misalignment which indicates overconfidence.
Source: THP Survey

83% of THPs with 1-5 years experience agree they know how best to treat Injured Workers compared to 100% for those with 16 years or more experience.
Source: Survey



THE BEHAVIOURAL ARCHITECTS

10 THPs struggle to recognize the need to adjust treatment that accounts for barriers to recovery

What is currently happening?

After a long treatment process a change is often required.

However, often these changes are not recognised by THPs, even after informal reassessment and communication with other THPs.

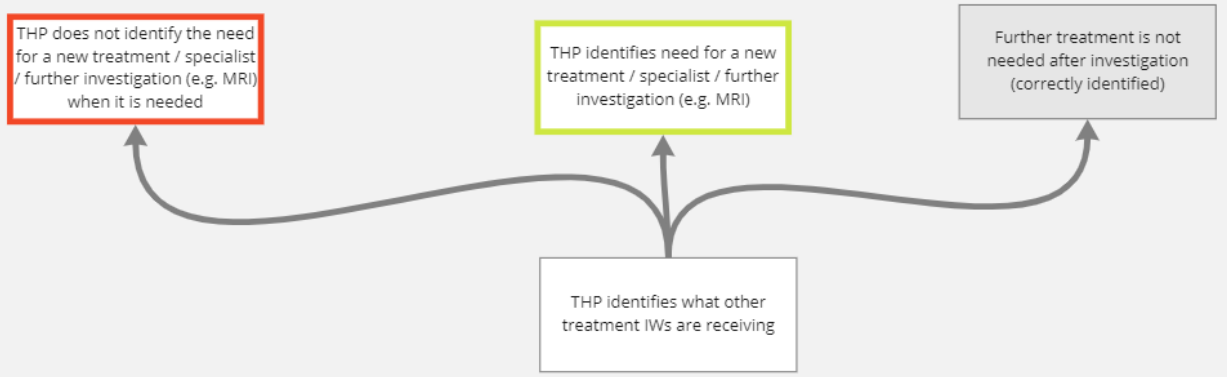
What are the consequences?

- Injured Workers do not get the treatment they require, which stalls recovery.
- Additional psychological barriers develop for the Injured Worker who begins to doubt their ability to recover.

When does the issue arise?

When progress has stalled and after the THP has contacted other THPs working with the patients to discuss barriers to recovery.

Refer to Journey Phase 7a-c of the TOC



"There are no timeframes in place so THPs are getting into the habit of continuing to see the patient and only refer as a last resort."
Exercise Physiologist, practice size 1-5, regional

"We are usually running under very limited time, so if you aren't working in a multidisciplinary way, then people won't do it because they aren't going to be paid for it."
Exercise Physiologist, practice size 6-10, metro

Status Quo Bias

THPs will stick to current treatment plans and avoid change rather than adapting to better treatment

11 THPs are not equipped to help Injured Workers combat low motivation and disengagement

What is currently happening?

Patients start to deviate from one another with some actively engaging in treatment and progressing well, whereas others are only passively following treatment and not progressing.

THPs are often ill equipped and not confident enough to help Injured Workers regain engagement and motivation.

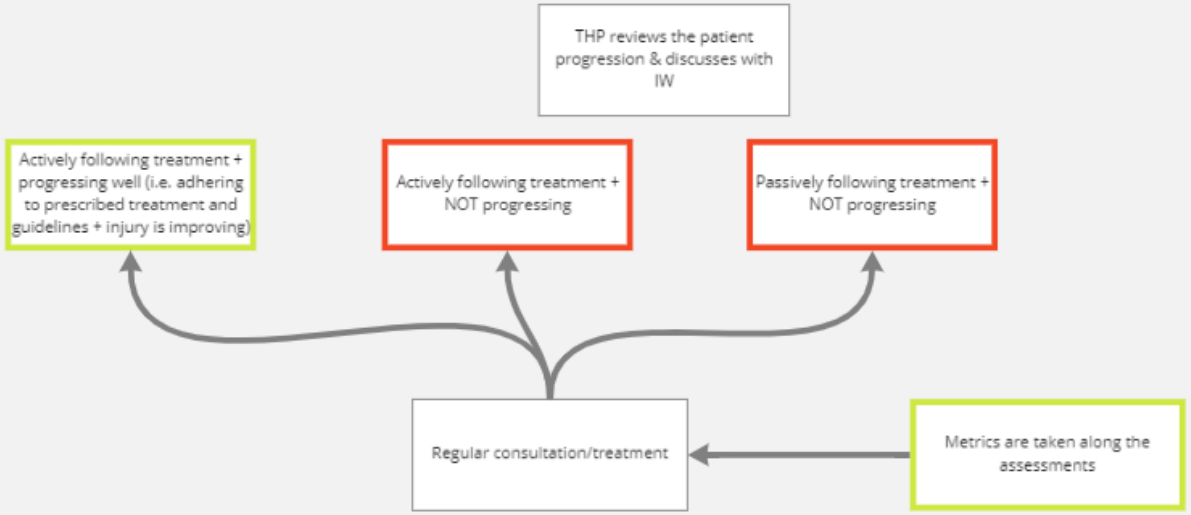
What are the consequences?

- Low engagement is never addressed or not addressed quickly enough
- Injured Workers are left in a state of disengagement and recovery slows or stops altogether.
- Without progress, secondary psychological barriers are built up which make it more difficult to recover in the long term

When does the issue arise?

Once treatment as been initiated and an Injured Worker is regularly attending appointments.

Refer to Journey Phase 6a-c of the TOC



"After so long without progress, everyone gives up and clients tend to become stagnant."
Exercise Physiologist, practice size 1-5, regional

5
Summary and Recommendations

There are four themes to the enablers of optimum care

Flexibility

When the compensation system allows for decisions at the discretion of THPs, the flexibility allows to tailor treatment towards the individual needs of Injured Workers.

Evidence

Evidence-based treatment increases consistency of THPs' treatment and can reassure Injured Workers about the quality of their treatment.

Accountability

Frequently reporting on effectiveness of a treatment approach promotes critical assessment of the chosen treatment.

Support

Receiving support with tasks that can be done by others enables THPs to focus on those tasks that require their expertise.

There are four themes to the identified barriers to optimal care

01

THPs take on too many roles

THPs need to fulfill too many roles that are not directly linked to their expertise to achieve high quality of care.

02

THPs treat without assessing progress

THPs treat without fully taking factors into account that are required to achieve biopsychosocial recovery and patient goals.

03

Communication is fraught with difficulty

Poor communication stemming from lack of time and mismatch of availability hinders informed treatment leading to optimal care.

Lack of trust between stakeholders and perceived self-serving nature further hampers collaboration.

04

Overconfidence fosters a lack of self-evaluation

The lack of critical re-evaluating of prescribed treatment and self-assessment skills that do not directly related to the profession leads to poorer treatment outcomes.

And 7 jobs recommended to achieve optimal outcomes

Empower Injured Workers
Support them to take ownership over their treatment, boosting motivation to proceed in times of adversity

Create supportive roles at home
Creating explicit private and personal roles to enable THPs to leverage support for Injured Workers

More nuanced reimbursement
Suitable remuneration helps THPs feel valued increasing their motivation to fully participate in care for Injured Workers

Increasing transparency
Improving access to treatment decisions facilitates more informed care

Streamlining admin processes
Reduces required effort and speeds up vital processes (e.g., approval of treatment plans)

Send timely reminders
Reduce the chances of THPs and supportive staff missing assessments and clarifications

Equip THPs with critical soft skills
Facilitate better support of Injured Workers e.g. how to increase motivation

Appendix 1
Rejected literature-based hypotheses

REJECTED LITERATURE-BASED HYPOTHESES

From the prior literature review and workshops, there were a number of theories as to what increases and decreases quality of care for Injured Workers

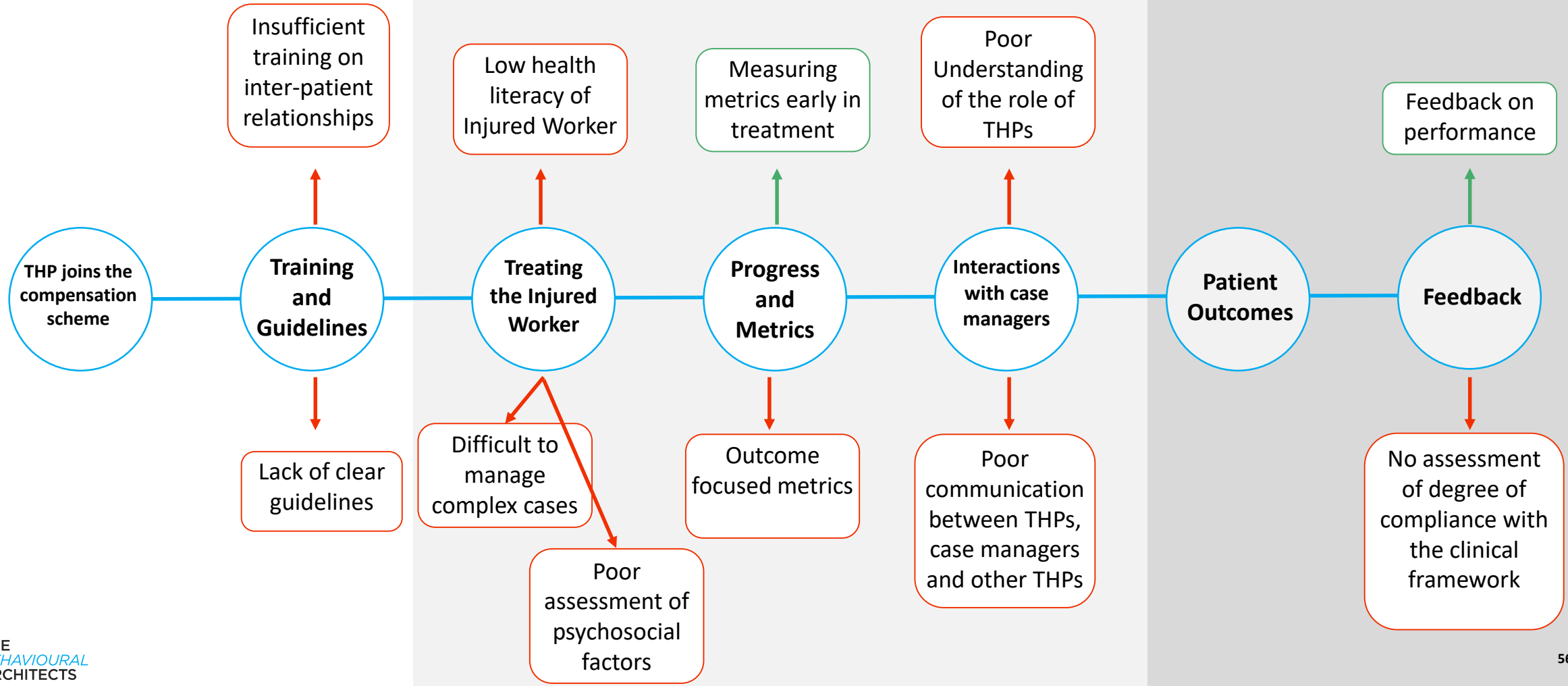
We have found that some of these were not relevant barriers to ideal care provided by THPs.

A summary of the hypothesised barriers based on literature review

Stage 1: Before Treatment

Stage 2: Treatment

Stage 3: After Treatment



Hypothesis #1

Biopsychosocial factors are not assessed because THPs receive insufficient training on the appropriate treatment of symptoms.

Hypothesis #1 is not supported

Biopsychosocial factors are often not assessed, but not because of lack of training

It is instead due to habit, lack of prompts, diffusion of responsibility or time scarcity.

Supporting research

Many THPs are assessing biopsychosocial factors informally, in a manner that fits their professional training.

31% of THPs say that they are equally likely to treat physical and psychological symptoms.
Source: THP Survey

"I assess psychological or social factors but not as rigid and structured, more in conversation. I ask about social history and family history."
Exercise physiologist, practice size 1-5, metro

"I do assess them, people often just talk to you and tell you what else is going on while you're treating them – sometimes I feel like the psychologist! If I give advice, it's sometimes just either just a casual recommendation – if I think it's worse than that, then I'll talk to their GP about referrals."
Physio, practice size 1-5, regional

Hypothesis #2

Lack of clear guidelines in the Clinical Framework increase reliance on “on the job training”

Hypothesis #2 is not supported

The Clinical Framework is used as general guide, if at all. It is not feasible to request frequent use.

THPs largely incorporate principals of the framework but do not consult it for immediate decisions.

Supporting research

Many THPs are familiar with the overarching content, while some THPs have not read the Clinical Framework or have read but do not remember it.

63% of THPs have read the Clinical Framework.
Source: THP Survey

"Clinical Framework, I looked at twice in my career to pull out pieces to reference for a patient."
Exercise physiologist, practise size 1-5, metro

"I don't use specific tools at the time [for treatment plan]. I've been doing this for a while. I've been integrating clinical guidelines."
Chiropractor, practise size +10, regional

Hypothesis #3

Providing feedback on performance gives clear direction and motivation to improve and builds better relationships with WSV

Hypothesis #3 is not supported

Feedback on performance may shift focus from patient care to competition

Supporting research

Receiving feedback was met with mixed feelings

Only **39%** of THPs agreed that gaining feedback will make it easier for them to treat Injured Workers.

Source: THP Survey

"Health professionals are a bit insecure. (…) Many other clinicians are insecure about being compared to other clinicians so they may not be comfortable.. I don't want clinicians focused on being compared to others."

Exercise physiologist, practice size 1-5, metro

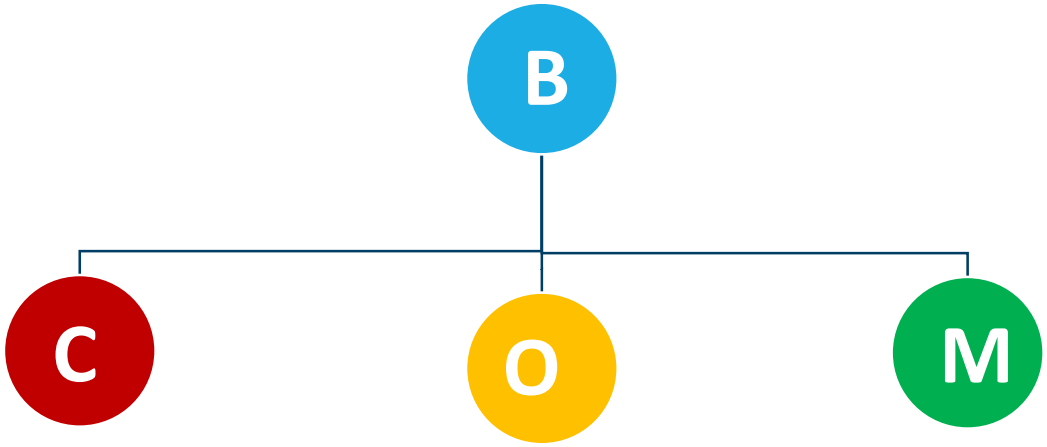
"I'm struggling with what feedback might entail and what it might achieve. (…) Claim agents would use it to make me act out of guilt and that is not in the interest of the Injured Worker."

Exercise physiologist, practice size 1-5, metro

Appendix 2
The COM-B model

What is COM-B?
It is a framework for diagnosing behaviour and how to create change

Behaviour = **C**apability **+** **O**pportunity **+** **M**otivation



Note that the three elements are interlinked and can feed into each other (see diagram on the right). For example, increased opportunity or higher capability might increase motivation.

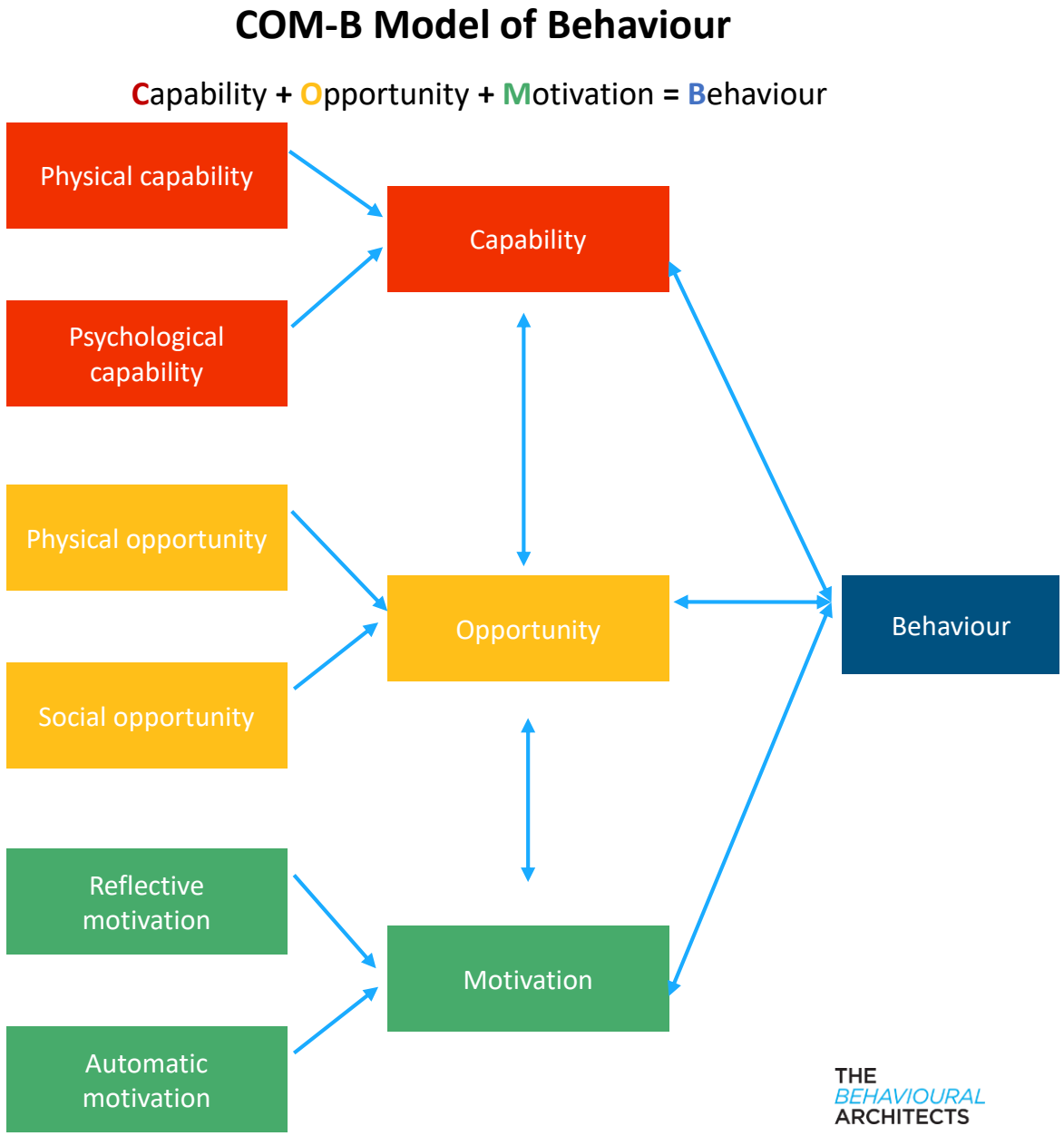
CAPABILITY

In this model capability is about whether an individual has the necessary skills and mental ability to do the desired behaviour. It centres on two broad types of capability:

Physical capability: this encompasses actions and motor skills learned through practice and training, such as driving; or simply sufficient physical strength or agility to do the desired behaviour.

Psychological capability: the second sub-element assesses whether someone has sufficient mental process or skill, for example, the memory, attention, decision-making ability or knowledge to do the desired behaviour. It can be broken down in four components:

1. knowledge;
2. cognitive or mental ability;
3. interpersonal skill (does someone need to persuade or work with someone else to achieve the behaviour); and
4. someone's ability to self-regulate i.e. control their behaviour and actions if needed.



OPPORTUNITY

This area involves factors that lie beyond the individual that might help enable a behaviour, make a behaviour possible, or prompt a behaviour - for example, prompts in the surrounding environment.

Physical opportunity: Prompts and triggers in the environment, availability of facilities and services, and even the structure of the physical surroundings might influence behaviour.

For example, do people have easy access to Wifi/broadband to enable them to access online services such as banking or welfare benefits? Or are there designated cycle routes that allow them to commute to work safely and easily?

Social opportunity: This considers whether people feel they have social permission to do the desired behaviour. Peer pressure might steer someone to do the target behaviour if they are aware of what others are doing or what others approve of. Therefore, awareness of social norms and people's perceptions of social norms are important here.

Are their perceptions accurate or do they underestimate the proportion of people around them doing the behaviour? Are there any role models already doing the behaviour? What is the culture and how is that affecting the target behaviour?

MOTIVATION

This involves analysing what might energise and direct behaviour. It's split into two sub-camps and differs from the previous model by placing equal emphasis on more considered, reflective types of motivation:

Automatic responses: how habits, emotional responses and impulses might automatically direct our behaviour, almost without thinking.

For example, a father seeing his child in distress is unlikely to even hesitate to come to her rescue. Habitual behaviours, like smoking, or even just locking the front door also govern our actions to the point where we don't even notice ourselves doing them.

Reflective thought: Conversely, there may also be occasions when we reflect on whether to do a behaviour, and carry out analytical, conscious thought, considering our various goals, plans, beliefs and identity in weighing up whether to go ahead.